ADVANCE COPY

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

January 6, 1993

ALL-COUNTY LETTER NO. 93-01

TO: ALL-COUNTY WELFARE DIRECTORS

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[X] Court Order or Settlement Agreement
[ ] Clarification Requested by One or More Counties
[ ] Initiated by SDSS

SUBJECT: IMPLEMENTATION OF MILLER V. WOODS II (Miller II)

REFERENCES: ALL-COUNTY INFORMATION NOTICE NO. 1-37-84
ALL-COUNTY LETTER NO. 84-58
ALL-COUNTY LETTER NO. 88-101
ALL-COUNTY LETTER NO. 88-110
ALL-COUNTY LETTER NO. 90-48

The Superior Court of San Diego entered an amended judgment in the Miller v. Woods II case on July 19, 1991. The purpose of this letter is to provide you with an overview of the court case as well as specific instructions and materials necessary to plan for its implementation. Attached are the following materials:

1. A copy of the Miller v. Woods II final court judgment.
2. A copy of the proposed draft regulations.
3. A copy of the Explanatory Flyer, the Provider Standard Claim Form, the Provider Supplemental Claim Form and the Eligibility Determination Worksheets.
4. IHSS Monthly Unearned Maximum Income and Resources Table.

Basis for Second Implementation of Miller v. Woods Court Order

As relayed in ACIN No. 1-37-84, on October 21, 1983 the Court of Appeal, Fourth District, invalidated Manual of Policies and Procedures (MPP) Section 30-463.233c, which prohibited payment to housemates and spouses for providing protective supervision, and ordered the California Department of Social Services (CDSS) to grant prospective and retroactive relief. On September 9, 1988, CDSS implemented the terms of this first judgment, called Miller I; however, because of difficulties with that implementation, the court issued an amended judgment on July 19, 1991 which directed the SDSS to take additional steps. This second effort is called Miller II, and among other things extends the claiming period from six to eight months, awards prejudgment interest on retroactive payments, and allows for claims for underpayments along with retroactive payments.

Proposed Emergency Regulations

Attached for your information and implementation planning purposes is a copy of the proposed draft regulations. The regulations are based upon the terms in the attached court judgment and are intended to provide a system by which retroactive and underpayment eligibility for protective supervision can be determined and payments made to eligible claimants.

It is anticipated that these regulations will become effective on, or near, February 1, 1993. Counties will receive an approved version of the emergency regulations through normal distribution procedures upon approval by the Office of Administrative Law and filing with the Secretary of State. In the meantime, Counties are encouraged to use the proposed draft regulations as a means for planning for the February 1, 1993 implementation of the Miller v. Woods II court case. It is anticipated that SDSS will provide training on the claim processing procedures for County Welfare Departments (CWDs), as well as for Administrative Law Judges (ALJs). Counties may contact Ms. Rosa Estes of the IHSS Policy Unit at (916) 657-2157 for any specific clarification or procedural instructions which may be needed.

Definition of "Claimant"

A claimant is defined as any person who files for retroactive payments under the Miller v. Woods II court case. What will distinguish those claimants who may be eligible for payments from those who will not is whether the claimant is found to be "class eligible." The "class eligible" criteria is defined in detail in the attached draft regulations. Briefly, class eligibles can be either recipients who, because they were denied protective supervision, paid a friend, relative or spouse to provide protective supervision during the retroactive period. Or, they can be friends, relatives or spouses who provided the service without IHSS compensation. Counties are instructed to accept all claims. If it is determined that the person filing the claim is not "class eligible," Counties are instructed to issue a Notice of Action (NOA) denying the claim with an explanation of why the individual was not determined to be class eligible.

Explanatory Flyers and Standard Claim Forms

Attached is a copy of the Explanatory Flyer (TEMP 2031), in English on one side and Spanish on the other, which will be sent to potential Miller v. Woods II claimants informing them of their potential entitlement to retroactive payments and underpayments. The TEMP 2031 and the Provider Standard Claim Form (TEMP 2000)

will be sent to all IHSS providers who have been identified through the Case Management Information and Payrolling System (CMIPS) as having lived at the same address as an IHSS recipient at any time from 1980 through November 1988. In Miller II there is a Recipient/Applicant Standard Claim Form (TEMP 2028) as well as the Provider Standard Claim Form.

Posters

The language on the posters (TEMP 2042), in English and Spanish, is modeled after the Explanatory Flyer. The central office in each County, as well as Social Security Administration (SSA) offices, legal aid organizations, independent living centers, Area Agencies on Aging (AAA), and Multipurpose Senior Services Program (MSSP) site locations will receive a supply of posters, as well as Explanatory Flyers and both types of Standard Claim Forms. These organizations are instructed to distribute a poster to each office having contact with the public and to ensure that the posters are placed in locations where they can easily be seen by the public, and distribute an Explanatory Flyer and the appropriate Standard Claim Form upon request. Counties are also instructed to distribute the poster to offices which administer Adult Services programs and have public contact, insure that the posters are placed where they may be viewed by the public, distribute the appropriate forms upon request, and provide assistance to claimants needing help completing the claim forms.

Supplemental Claim Forms

The Supplemental Claim Forms, for providers (TEMP 2001) and recipient/applicants (TEMP 2029) are to be kept on hand in those offices where it has been determined that claims will be processed. The Supplemental Claim Form is to be issued to claimants only after a Standard Claim Form has been completed and the County is unable to locate either a record of an approved or a denied IHSS case, or the available case record does not contain sufficient information for determining retroactive IHSS eligibility.

Part III on the form asks the claimant for the average monthly income and resources of the person who received protective supervision. Counties are instructed to compare the monthly amounts provided by the claimant with the amounts on the income and resources table described below. Any period(s) claimed in which either the income and/or resources are above the amounts on the attached table would constitute a denial for that period(s).

Mailing of Court Case Materials

A supply of the forms, flyers and posters will be sent to the Miller II contact person in each County during January 1993. Each County contact is responsible for distributing the Posters, Explanatory Flyers and Standard Claim Forms to district offices which administer Adult Services programs and have public contact. Counties needing additional quantities may order through the CDSS warehouse by completing a GEN 727B and identifying the material(s) needed by form number. The surplus of materials being stored in the warehouse is limited. Counties are therefore instructed to request only those amounts actually needed. Pending the receipt of any ordered materials, Counties may wish to photo copy any of the flyers and/or forms as needed. Below is a list of all forms used in the implementation of Miller II by the claimant and the CWD in processing the claims:

Temp 2042	Miller v. Woods Poster
Temp 2031	Miller v. Woods Explanatory Flyer
Temp 2000	Miller v. Woods Provider Standard Claim Form
Temp 2001	Miller v. Woods Provider Supplemental Claim Form
Temp 2003	Miller v. Woods Provider Retroactive Payment Eligibility Determination Worksheet
Temp 2002	Miller v. Woods Provider Underpayment Eligibility Determination Worksheet
Temp 2028	Miller v. Woods Applicant/Recipient Standard Claim Form
Temp 2029	Miller v. Woods Applicant/Recipient Supplemental Claim Form
Temp 2027	Miller v. Woods Applicant/Recipient Retroactive Payment Eligibility Determination Worksheet
Temp 2030	Miller v. Woods Applicant/Recipient Underpayment Eligibility Determination Worksheet

IHSS Maximum Unearned Income and Resources Table

Attached as page 8 of this ACL is an IHSS Maximum Unearned Income and Resources Table for the retroactive payment and underpayment claim periods. Counties are instructed to use these income and resource limits when retroactive and underpayment eligibility for IHSS must be established through the use of the Supplemental Claim Form. If, for any period claimed, the amounts on the Supplemental Claim Form indicate that the income and/or resources of the person claimed to have received protective supervision are higher than the income/resource amounts on the Table, Counties are to deny the claim for the period in which the amounts are higher. Counties are instructed to limit the use of the Table to Miller v. Woods cases only.

Authorized Representatives

An authorized representative is defined as a legal conservator, an executor, or any other individual having a written statement signed by the claimant verifying that he/she has been given written authorization to act on behalf of the claimant. It is possible that a recipient may be deceased and his/her estate could be potentially eligible for retroactive payments and underpayments. In these instances, the executor of the estate must act as the deceased claimant's authorized representative. Counties are instructed to obtain written verification from the individual claiming to be the legal/authorized representative.

Reopened Miller I Cases

CDSS, through CMIPS, will reopen Miller I claims which were denied solely for filing after the Miller I final filing date of March 9, 1989, and send a list of reopened Miller I claims to each County. EDS will send these individuals a notice informing them that their Miller I claim has been reopened, and a Standard Claim Form in order for them to claim underpayments. These Miller I reopened claims will be processed for retroactive payments and underpayments using the enclosed regulations. Miller I claims that are returned as undeliverable will be remailed using updated addresses if possible and with an CDSS return address. Miller I claims that are returned as undeliverable a second time will be returned to the appropriate County who shall mail the original NOA if County records contain an updated address. If there is no updated address or the NOA is returned a third time, the County will prepare and mail a denial NOA to be included in the case file to serve as evidence of lost contact and final closure of the claim.

County Transfer Procedures

Counties which receive a Miller II claim where services were provided or received either fully or partially in another County shall transfer the full or partial claim to the other County(ies) by sending a copy of the claim to each affected County. The CWD shall also send a Notice of Action to the claimant within ten calendar days of the filing date notifying the claimant of the transfer. This procedure will also apply to reopened Miller I claims. CMIPS procedures regarding County transfers will be transmitted under separate cover.

County Statistical Reporting

The Miller II amended judgment requires CDSS to compile monthly statistical information on claims for retroactive payments and underpayments, as well as the status of reopened Miller I claims. The information required will be collected through CMIPS. It is therefore important that Counties carefully follow the CMIPS instructions, which will soon be released, so that accurate counts may be obtained.

Case Retention

Counties were advised in All-County Information Notice No. 1-37-84 to avoid destroying any case files, applications, denials or other records pertinent to cases which may be eligible for retroactive payments (i.e., recipients with housemates). For ease in locating case records once the claim period begins, Counties may now wish to retrieve any case records or documents which may have been identified as potentially eligible Miller II cases, as well as any information related to Miller I claims filed under Miller I.

Related to this is a requirement contained in the Miller II regulations which instructs Counties to retain any and all information received and/or obtained regarding Miller I and Miller II claims in case related files.

It is anticipated that CDSS will conduct Miller II case reviews in late 1993 or early 1994. Counties are instructed to retain all approved and denied Miller I and Miller II case files for at least the normal three-year retention period. This includes any claims which may be filed after the end of the claim period. If it is determined that a need exists to retain these cases/claims beyond the three-year period, Counties will be notified through a future All-County Letter.

Funding for County Administration of Court Case Related Activities

Statewide funds for the administration of each of the court cases will be allocated using the same methodology as that used for Miller I described in ACL No. 88-101, or on the basis of each County's percent to statewide total of IHSS caseload activity with each County guaranteed a minimum allocation of $100.

Additionally, when performing case related activities including receiving applications, researching case records to determine eligibility, calculating payments and capturing data involving CMIPS, County workers will time study to IHSS staff activities and not to a separate line item.

The CMIPS instructions and procedures will be mailed to Counties under separate cover. In the meantime, information needed for planning purposes should be directed to Wayman Hindsman at (916) 657-2134.

Any questions regarding Miller v. Woods II policy and implementation of the regulations should be directed to Rosa Estes at (916) 657-2157.

JAMES W. BROWN
Acting Deputy Director
Adult and Family Services

Attachment

cc: CWDA

MILLER VS. WOODS II COURT CASE

IHSS MONTHLY UNEARNED INCOME MAXIMUM TABLE FOR INDIVIDUALS

PERIOD COVERED	AGED/DISABLED		BLIND	
	NSI	SI	NSI	SI
1/79 thru 6/79	$758.60	$948.60	$796.60	$986.60
7/79 thru 6/80	$836.00	$1040.00	$850.00	$1083.00
7/80 thru 12/80	$954.00	$1189.00	$1003.00	$1238.00
1/81 thru 6/81	$972.00	$1207.00	$1023.00	$1258.00
7/81 thru 6/82	$1040.00	$1297.00	$1093.00	$1350.00
7/82 thru 6/83	$1052.00	$1309.00	$1107.00	$1364.00
7/83 thru 12/83	$1085.00	$1353.00	$1140.00	$1408.00
1/84 thru 6/84	$1101.00	$1369.00	$1159.00	$1427.00
7/84 thru 12/84	$1135.00	$1418.00	$1193.00	$1476.00
1/85 thru 6/85	$1162.00	$1445.00	$1223.00	$1506.00
7/85 thru 8/85	$1198.00	$1498.00	$1259.00	$1559.00

The resource limit for the period 1/79 through 12/84 was $1500 for an individual and $2250 for a couple. From 1/85 through 8/85, the resource limit was $1600 for an individual and $2400 for a couple.

This table is to be used only in determining eligiblity for MILLER v. WOODS II cases.

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Attorneys for Petitioners/Plaintiffs

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SAN DIEGO

HAROLD and JOSEPHINE MILLER,

Petitioners,

v.

MARION J. WOODS, Director, State Department of Social Services,

Respondent.

CASE NOS. 468192, 472068
531015

JOINT MOTION TO APPROVE AMENDED JUDGMENTS

Date: July 19, 1991
Time: 9:00 a.m.
Dept: 4
Trial date: None

WELFARE RIGHTS ORGANIZATION OF SAN DIEGO, INC., et al.

Petitioners/Plaintiffs,

v.

LINDA S. McMAHON, et al.,

Respondents/Defendants.

The parties submit the amended judgments in these cases for the court's approval. The amended judgments, like the original ones, will be implemented together in two stages: claims processing and monitoring.

The court should approve them because they are fair and adequate to the class. (Anthony v. Superior Court (1976) 59 Cal.App.3d 760, 771-72.) The court has previously ordered and approved the basic changes in the amended judgments.

The changes in the judgments cover the claims processing stage. They incorporate the court's Order Re Motion For Supplemental Relief (filed Nov. 19, 1990) in Miller, the agreements in the Joint Status Report (filed Mar. 22, 1991), and technical changes from later negotiations. The changes set out the basic steps for DSS to follow in enough detail, particularly in light of the problems in Miller I, to avoid future implementation problems.

The key to monitoring DSS's actions during the claims processing stage is the bimonthly reports to class counsel. With such regular and timely information, the parties believe they can work out the details of implementation without court action. The claims processing stage will be completed in eighteen (18) months by DSS estimate.

The court should set the next status conference for December, 1992. The parties anticipate that the only judicial action in this case will be to approve a monitoring plan and the final DSS compliance with the judgments.

FILED
KENNETH E. MARTONE
Clerk of the Superior Court
JUL 19 1991
By: P. BERNSTEIN, Deputy

SUPERIOR COURT OF THE STATE OF CALIFORNIA
COUNTY OF SAN DIEGO

HAROLD AND JOSEPHINE MILLER, Petitioners v. MARION J. WOODS, Director of the State Department of Social Services, Respondent.	CASE NO. 468192
COMMUNITY SERVICES CENTER FOR THE DISABLED, et al., Petitioner/Plaintiffs v. MARION J. WOODS, et al., Defendants.	CASE NO. 472068 AMENDED JUDGMENT

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The parties Joint Motion To Approve Amended Judgment was heard on July 19, 1991. Charles Wolfinger appeared as counsel for petitioners/plaintiffs ("petitioners"). Michael V. Hammang, Deputy Attorney General of the State of California, appeared as counsel for respondents/defendants ("respondents").

The court has considered the decision of the Court of Appeal, Fourth District, in Miller v. Woods, 148 Cal.App.3d 862 (1983), the pleadings and papers on file herein and the arguments of counsel, and being fully advised in the premises, now therefore,

HEREBY ORDERS, ADJUDGES, AND DECREES:

I. CLASS CERTIFICATION - This suit is certified and may proceed as a class action for a declaratory judgment and a writ of mandate under Code of Civil Procedure (C.C.P.) Section 1085. The class is defined as:

> all applicants for and recipients of In-Home Supportive Services (IHSS), and their housemate providers, who have been since April 1, 1979 or will be disqualified from receiving protective supervision services or compensation therefor, solely because of respondents' enforcement of Manual of Policies and Procedures (MPP) Section 30-763.233c or the continuing effects thereof.

II. DECLARATORY JUDGMENT - This court makes the following declaration of the parties' rights pursuant to C.C.P. Section 1060:

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A. Invalidity of MPP Section 30-763.233c - MPP Section 30-763.233c (formerly numbered MPP Section 30-463.233c) is invalid for the reasons set forth in Miller v. Woods, supra, 148 Cal.App.3d at 876-81, because it conflicts with:

1. Welfare and Institutions Code Sections 12300, 12301, 12304, 12304.1, and 12350;

2. the Rehabilitation Act of 1973, 29 U.S.C. Section 794, and implementing federal regulations, 45 C.F.R. Section 84.4(b) (1980); and

3. the equal protection guarantees in Article I, Section 7 of the California Constitution and the Fourteenth Amendment to the United States Constitution.

B. Entitlement to Retroactive Benefits - The individually named petitioners and the class are entitled to restoration of all IHSS compensation for protective supervision services provided that was denied solely pursuant to respondents' enforcement of MPP Section 30-763.233c for the following periods:

1. Non-spouse providers - Non-spouse petitioners and class members are entitled to retroactive benefits for the period from April 1, 1979 through April 30, 1984.

2. Spouse providers - Spouse petitioners and class members are entitled to retroactive benefits from April 1, 1979 through July 31, 1981.

C. Entitlement to Underpayments - Class members are entitled to underpayments from May 1, 1984 through August, 1985

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for county errors in failing to correctly pay for protective supervision. Underpayments shall be issued in accordance with Departmental regulations found at MPP Section 30-768.4.

D. Entitlement to Prejudgment Interest - Those named petitioners and class members determined eligible for retroactive benefits are entitled to prejudgment interest at the statutory rate on the amount of benefits. The period of entitlement begins on the date when the payment was originally owed if MPP Section 30-763.233c had not been enforced, and ends on the last day of the month following the month in which payment is authorized.

E. The Need for Immediate Implementation of the Judgment - Any delay in implementing the terms of this Judgment will:

1. deprive IHSS applicants and recipients of housemate providers;

2. increase the risk of institutionalization of persons otherwise able to remain in their homes with a housemate provider compensated under the IHSS Program;

3. impose substantial economic hardship on housemate providers who have provided or continue to provide uncompensated protective supervision services to eligible applicants and recipients; and

4. impose substantial economic hardship on recipients who have paid housemate providers for protective supervision and who have not been compensated under the IHSS Program.

III. WRIT OF MANDATE FOR PROSPECTIVE ENFORCEMENT - Let the writ of mandate issue pursuant to C.C.P. Section 1085 on behalf of petitioners and the class defined in paragraph I, commanding respondent Woods, his successors in office, officers, employees, agents, representatives, and all other persons acting in his behalf or subject to his control or supervision, including his statutory agents, the board of supervisors of each county of California and the directors of each county welfare department to:

A. Cease Enforcing MPP Section 30-763.233c - Cease enforcing MPP Section 30-763.233c or any similar policy or practice in any manner that denies an otherwise eligible person protective supervision services or compensation therefor solely because the provider is a housemate.

B. Voluntary Service Regulations - Promulgate regulations to require a statement signed by the provider when the provider agrees to provide voluntarily any compensable services. The statement shall indicate that the provider knows of the right to compensated services but voluntarily chooses not to accept any payment or reduced payment for the provision of services.

C. Provide Claim Information - For a period of eight months following the effective date of the beginning of the claim period as contained in the regulations (described in paragraph V) supply any person who inquires about eligibility for benefits under this judgment, however described, with the Claim Form, Supplemental Claim Form and the Explanatory Flyer.

IV. WRIT OF MANDATE FOR IDENTIFYING AND NOTIFYING CLASS MEMBERS OF THEIR RIGHTS TO RETROACTIVE RELIEF - Let the writ of mandate issue pursuant to C.C.P. Section 1085 on behalf of the persons and commanding the persons described in Paragraph III to:

A. Identify All Individual Provider Class Members -Use the IHSS Payrolling System data from January 1, 1980 to November 30, 1988 to identify individual providers who at anytime lived at the same address as a recipient as follows:

1. January, 1980 through April, 1984: all providers sent notices in Miller I, including those with granted claims;

2. May, 1984 through June, 1986: all providers with the same address as recipients, not including any in A.1 above;

3. July, 1986 through November, 1988: providers with the same address as recipients who were authorized protective supervision, not including any in A.1 or A.2 above.

B. Reopen Claims Denied As Untimely Filed

DSS will take the following steps to reopen and process claims denied as untimely filed in Miller I:

1. By CMIPS contractor, identify and produce a list by county of all claims denied as untimely filed up to June 30, 1989;

2. Send each county the list in IV.B.1;

3. Develop a special notice for claimants

whose cases are reopened;

4. Mail this notice to each claimant at the latest address available to CMIPS contractor;

5. Instruct counties to process reopened claims during the regular Miller II claims process according to the regulations, forms and instructions developed for that process.

6. Ensure separate reporting for reopened claims.

C. Notify All Class Members Of Their Right To Retroactive Relief

1. For each class member identified under subparagraph IV. A:

a. Determine the current mailing address by using services provided by the Franchise Tax Board; and

b. By no later than the effective date of the beginning of the claim period as contained in the regulations (paragraph V) send to the current address by first class mail a copy of the IHSS Protective Supervision Explanatory Flyer (Attachment 3) and Claim Form set forth in subparagraphs IV C 3 and 5 below.

2. Public Notices - Issue Standard Claim Forms, Explanatory Flyer (Attachment 3) and posters in English and Spanish in the size of 17" x 22" modeled after the Explanatory Flyers, in sufficient numbers to each of

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the following:

a. Each county welfare department with instructions to display the posters in prominent locations in every office having contact with the public for the eight (8) month period beginning with the effective date of the beginning of the claim period as contained in the regulations described in Paragraph V.

b. All interested organizations and groups listed in Appendix A with a request to display the posters in a prominent location and to distribute the Explanatory Flyer and Standard Claim form on request for the eight (8) month period beginning with the effective date of the beginning of the claim period as contained in the regulations described in Paragraph V.

c. Posters only will be sent to Federal Social Security Administration offices with a request to display them in a prominent location for the eight (8) month period beginning with the effective date of the beginning of the claim period as contained in the regulations described in Paragraph V.

3. Standard Claim Form - The standard claim form shall be written in plain English and substantially conform to Attachment 1 hereto, except as amended in Section V-E below. A supply of forms translated into Spanish shall be kept on hand and disbursed upon request.

4. Supplemental Claim Form - The supplemental

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claim form shall be written in plain English and substantially conform to Attachment 2 hereto, and include proof of age, blindness or disability. The supplemental claim form shall be used for claimants where the person requiring protective supervision was not previously authorized IHSS benefits. A supply of forms translated into Spanish shall be kept on hand and disbursed upon request.

5. Explanatory Flyer - The Explanatory Flyer shall be written in plain English and Spanish in substantial conformity to Attachment 3 hereto.

D. Remailing Returned Notices

1. Seek to obtain approval of the plan from appropriate State agencies (Department of Finance, Department of General Services, Franchise Tax Board (FTB), Health and Welfare Agency, and others as required), discuss any problems with plaintiffs' counsel and supply all documentation and contracts with him before execution.

2. By CMIPS contractor, make a list with provider name, sequential CMIPS number, CMIPS contractor, address and Social Security Account Number (SSAN).

3. By FTB, update CMIPS contractor list from D.2.

4. By FTB, code each updated address by FTB or IRS source.

5. By FTB, sort by CMIPS

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contractor, FTB or IRS Code mail returned as undeliverable within the first three months following the completion of mailing.

6. By FTB, develop a list of returned mail with name and CMIPS contractor sequential number and either the FTB updated or CMIPS contractor updated address (none for IRS updated address), and send weekly to CMIPS contractor.

7. By DSS or other organization to be determined, develop a list with name, address and SSAN, and send weekly to contracted private credit reporting agency.

8. DSS will arrange to remail all updated addresses from private credit reporting agency and allow for a minimum of two months from the date of the last remailings for persons to file claims.

9. Take no further action to update or mail all returned notices from second mailing. These returned notices will be destroyed.

V. WRIT OF MANDATE FOR PROCESSING CLAIMS FOR RETROACTIVE BENEFITS - Let the writ of mandate issue pursuant to C.C.P. Section 1085 on behalf of the persons and commanding the person described in paragraph III to promulgate and implement regulations regarding the following:

A. Claiming Period - Claims for retroactive benefits shall be accepted at all county welfare department offices for a period of eight (8) months, beginning with

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contractor, FTB or IRS Code mail returned as undeliverable within the first three months following the completion of mailing.

6. By FTB, develop a list of returned mail with name and CMIPS contractor sequential number and either the FTB updated or CMIPS contractor updated address (none for IRS updated address), and send weekly to CMIPS contractor.

7. By DSS or other organization to be determined, develop a list with name, address and SSAN, and send weekly to contracted private credit reporting agency.

8. DSS will arrange to remail all updated addresses from private credit reporting agency and allow for a minimum of two months from the date of the last remailings for persons to file claims.

9. Take no further action to update or mail all returned notices from second mailing. These returned notices will be destroyed.

V. WRIT OF MANDATE FOR PROCESSING CLAIMS FOR RETROACTIVE BENEFITS - Let the writ of mandate issue pursuant to C.C.P. Section 1085 on behalf of the persons and commanding the person described in paragraph III to promulgate and implement regulations regarding the following:

A. Claiming Period - Claims for retroactive benefits shall be accepted at all county welfare department offices for a period of eight (8) months, beginning with

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the effective date of the beginning of the claim period as contained in the retroactive regulations implementing this judgment.

1. The date of filing for retroactive benefits claims shall be determined as follows:

a. If the claim is mailed to the county welfare department, the date of filing shall be the date postmarked on the envelope.

b. If the claim is filed in person at the county welfare department, the date of filing shall be the date stamped on the claim.

c. If the date cannot be determined by a. or b. above, the date of filing shall be the date the claim was signed.

B. Eligibility Conditions For Retroactive Benefits - The eligibility conditions for receipt of retroactive benefits are:

1. The IHSS recipient or applicant met the (a) general IHSS eligibility conditions, and (b) the specific conditions for having a need for protective supervision, in effect during each month for which retroactive benefits are claimed.

2. The provider was a housemate provider who performed protective supervision services for the eligible recipient or applicant during the month claimed.

3. The recipient or applicant received

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less than the applicable statutory grant maximum during the month claimed, including any share of costs.

4. Claimants whose claim forms establish that they do not meet the eligibility conditions in subparagraphs V B 1-3 as above shall be denied retroactive benefits.

C. Retroactive Claims Processing Procedures -The procedures for processing claims for retroactive benefits will substantially conform to the following steps:

1. Standard Claim Form -

a. All initial claims for retroactive benefits must be filed on the claim form described in subparagraph IV C 3 above. A class member who files a claim form shall be referred to as a claimant in this judgment.

b. The claim form must be filled out completely and signed and dated by the claimant under penalty of perjury and witnessed. If the claim form has not been completely filled out, or if the claimant or a witness has not signed and dated the claim form, the claim shall be denied for insufficient information. The claimant shall be sent a Notice of Action denying the claim with an explanation of the information needed to complete the claim form. The claimant shall be allowed forty-five (45) days from the date of the Notice to submit the additional information. If the information is not received within the forty-five (45) days, the denial will stand.

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2. Place for filing claims - Claims for retroactive benefits shall be filed with the welfare department in the county in which the claimant currently resides. If protective supervision was provided or received in a different county, the local county welfare department shall forward the claim to the county where the service occurred.

3. Retroactive payment period -Retroactive benefits shall be paid to claimants who paid for or who provided protective supervision services within the period specified in subparagraph II.B, but were not compensated under the IHSS Program solely because of respondents' enforcement of MPP Section 30-763-233c.

4. General proof requirements -Information and verification supplied by or on behalf of the claimant shall be limited to that required by the Standard Claim Form or the Supplemental Claim Form.

5. Recipient status and income eligibility - The existing case files and information supplied according to subparagraph V C 4 above will be used to establish all eligibility conditions to the maximum extent without further proof by the claimant.

6. Recipient's need for protective supervision -

a. An applicant or a recipient is presumed to have needed protective supervision:

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1) If a need was assessed at any time (in which case the need shall be from that time forward) or;

2) An applicant's or a recipient's need is established by a sworn statement from the claimant and verified by a witness.

b. The county welfare department shall review the case file and may obtain other information to support or to rebut the eligibility determination made in subparagraph V C, but must advise the claimant of any adverse contradictory information regarding the recipient's need for protective supervision and give an opportunity to submit further information supporting the claim. The claim shall be denied if the claimant is found to be ineligible.

7. Protective Supervision Services Provided

a. If a claimant shows that protective supervision services were rendered, the county welfare department must presume that the provider did not render them voluntarily.

b. The provision of services may be established by the claimant's sworn statement verified by a witness concerning the approximate number of hours per day, and by any other readily available information in the claimant's possession, taking into account the abilities of the claimant.

c. The county welfare department may obtain additional information to verify the claimant's

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statement, but must advise him of any adverse contradictory information and give him forty-five (45) days from the date of the Notice to submit further information supporting the claim.

8. Computation of the amount of retroactive benefits - The county welfare department shall determine the amount of retroactive benefits due for each month based upon the following:

a. For claimants who were authorized IHSS, the amount of retroactive benefits due for each month claimed shall be the lesser of, either (1) the difference between the applicable IHSS statutory maximum for each month for which benefits are claimed and the amount of IHSS benefits the recipient was authorized to receive, or 2) the amount of protective supervision claimed. The amount of benefits due shall not exceed the statutory maximum for the months claimed.

b. For claimants who were not authorized IHSS, the amount of retroactive benefits due shall be the number of protective supervision hours provided and claimed multiplied by the county's applicable individual provider hourly wage during each month for which benefits are claimed. The amount of benefits shall not exceed the statutory maximum for the periods claimed.

c. Any recipient share of cost shall not be considered when computing the amount of retroactive benefits due to the claimants in paragraph V C 8 b.

/ /

/ /

d. The amount of prejudgment interest shall be calculated thereon from date originally due through the last day of the month following the month in which payment is authorized.

9. CMIPS Contractor Reporting - The county welfare department shall submit all necessary documents to the CMIPS Contractor so that payment of retroactive benefits may be issued within thirty (30) days from the date the Notice of Action is mailed. However, DSS shall mail out the payments on or before the 10th of the month, and otherwise shall hold the payments for issuance until on or before the 10th of the following month.

10. Standard Eligibility Determination Worksheet - DSS shall design a Standard Eligibility Determination Worksheet for use by county welfare departments to facilitate the eligibility determinations required to process a claim for retroactive benefits.

11. Notice of Action - County welfare departments shall issue and mail a Notice of Action on each claim within sixty (60) days from the date of receipt of the claim form containing the following information:

a. For every month for which retroactive benefits are claimed:

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LIFORNIA
REV. 8-72)

(1) The computation for the amount due, with and without prejudgment interest, or

(2) The reasons and facts explaining why no amount is due, or why less than the amount claimed is due, including a statement of what additional information is needed (if the reason is insufficient information) and that the claimant must provide it within forty-five (45) days from the date of the Notice.

b. The total amount of retroactive benefits determined due each year and the amount of prejudgment interest thereon.

c. The allocation of any amount due the provider and/or the recipient.

d. A statement regarding withholding taxes.

e. Advice about the right to a state hearing and the procedures for obtaining one.

12. State Hearing - Grant each claimant or authorized representative a state hearing which conforms to the procedures set forth in Welfare and Institutions Code Section 10950 and MPP Sections 22-000 et seq. to contest any adverse action regarding these retroactive benefits.

D. Regulations

1. Provide plaintiffs' counsel with the text of the proposed regulations 30 days before filing them with the Office of Administrative Law.

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2. Respondents shall use their best efforts to issue emergency regulations to implement this judgment.

E. Underpayments Claim Processing - DSS will take the following steps to process underpayment claims in Miller II:

1. Set the Miller underpayment period from May, 1984 through August, 1985;

2. Revise the claim forms to specify underpayments for the period in E-1 and to allow for claiming by month for hours of service;

3. Revise county worksheet to include documentation for underpayment claims and calculations.

4. Issue Notices of Action for underpayment claims decisions.

5. Include all underpayment forms used in case file.

6. Develop a monthly reporting system for county and state totals for underpayment applications, pending, approved, and denied, and total underpayments.

VI. WRIT OF MANDATE FOR MONITORING COMPLIANCE WITH THIS JUDGMENT - Let the writ of mandate issue pursuant to C.C.P. Section 1085 on behalf of the persons and commanding the persons described in paragraph III to take the following actions:

A. Statistical Reports - Beginning with the third month following the beginning of the claim period as

contained in the retroactive regulations, and continuing throughout the claims processing period, DSS shall produce monthly statistical reports. These reports shall contain the following information:

1. Number of claims received;

2. Number of claims denied;

3. Number of claims approved;

4. Number of claims pending;

5. Amount of benefits approved.

B. CMIPS Contractor Reports - Respondents shall obtain from CMIPS contractor a final report by county that includes:

1. Number of claimants paid.

2. Total amount of retroactive benefits paid.

3. Number of underpayments paid.

4. Total amount of underpayments paid.

C. Case Reviews

1. Respondents shall provide plaintiffs'counsel with a copy of the monitoring plan for case reviews at least 60 days before it is implemented. The plan shall include:

a. The 15 counties to be reviewed. Based on the monthly reports described above, the 15 counties shall be those having the largest number of claims over the eight-month claiming period;

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b. The number of cases to be reviewed in each county and the method used to select them;

c. The personnel who shall conduct the case reviews and the training they shall receive;

d. The procedures to be followed in conducting the case review; and

e. The format for the results.

2. Respondents shall provide plaintiffs' counsel with copies of all monitoring documents and all findings and make available all documents generated as a result of any monitoring activity.

VII. RETENTION OF JURISDICTION - This court retains jurisdiction over this case for the following:

A. Ensure Compliance -

1. Ensure compliance with the judgment and make such further orders as may be necessary therefor until DSS demonstrates compliance with this judgment.

2. Require DSS to send class counsel a bimonthly status report about all actions taken on the judgment and include any basic implementation records; the first report is due thirty (30) days from the date of this judgment.

3. Require DSS to include in contracts with other agencies an accurate account of all transactions.

B. Attorney's Fees and Costs - Rule on any motion for attorney's fees and any requests for costs filed by plaintiffs or their counsel for work after February 11, 1988.

This judgment modifies any and all statutory or other time limits including C.C.P. Section 1033, for making a request for costs and/or attorney's fees.

DATED: JUL 1 9 1991

MICHAEL I. [illegible]

JUDGE OF THE SUPERIOR COURT

PAPER
F CALIFORNIA
3 (REV. 8-72)

MILLER \ WOODS

STANDARD CLAIM FORM

INSTRUCTIONS: *Please print. Fill in as much information as you can. If you need help, call, or go into your county welfa department. Sign your name in Section 6 and have someone who knows that you provided the servic sign in Section 7.*

REMEMBER: **You must get this claim form to the county welfare department by March 9, 1989 to get any money**

YOUR NAME

1.

SOCIAL SECURITY NUMBER | TELEPHONE NUMBER ( )

CURRENT ADDRESS: (NUMBER, STREET) | APARTMENT/SPACE NUMBE

CITY | COUNTY | STATE | ZIP CODE

	YES	NO	UNKNOWN
A. Did you live with a mentally ill, mentally impaired or confused person who would get hurt or injured if left alone?	☐	☐	
B. Did you stay and watch out that the person did not get hurt or injured at any time from April 1979 to May 1984?	☐	☐	
C. Were you a relative, friend or spouse of that person?	☐	☐	
D. Did that person apply for and receive In-Home Supportive Services (IHSS) at any time from April 1979 to May 1984?	☐	☐	☐
If no, was the person denied IHSS benefits at any time from April 1979 to May 1984?	☐	☐	☐

ADDRESS AT TIME YOU PROVIDED PROTECTIVE SUPERVISION IF DIFFERENT FROM ABOVE

UMBER, STREET:

APARTMENT/SPACE NUMBER

ITY | COUNTY | STATE | ZIP CODE

NAME OF PERSON YOU PROVIDED PROTECTIVE SUPERVISION TO: | HIS/HER SOCIAL SECURITY NUMBER (Optional) | TELEPHONE NUMBER ( )

URRENT ADDRESS: (NUMBER, STREET) | APARTMENT/SPACE NUMBER

Y | COUNTY | STATE | ZIP CODE

LATIONSHIP TO YOU

ON THE BACK OF THIS FORM LIST THE MONTHS AND HOURS THAT YOU PROVIDED PROTECTIVE SUPERVISION FOR WHICH YOU WERE NOT PAID.

I UNDERSTAND THAT THE INFORMATION PROVIDED ABOVE IS SUBJECT TO VERIFICATION AND THAT MY SIGNATURE ON THIS FORM IS AN AUTHORIZATION FOR SUCH INVESTIGATION.

I, THE UNDERSIGNED, DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

IATURE OF PROVIDER: | DATE:

I, THE UNDERSIGNED, DECLARE UNDER PENALTY OF PERJURY THAT THE PERSON NAMED IN "1" ABOVE PROVIDED PROTECTIVE SUPERVISION (AS ESCRIBED ON THIS CLAIM FORM) TO THE PERSON NAMED IN "2" ABOVE.

IATURE OF WITNESS: | DATE:

TIONSHIP TO PROVIDER | RELATIONSHIP TO PERSON TO WHOM PROTECTIVE SUPERVISION WAS PROVIDED

RESS: (NUMBER, STREET) | APARTMENT/SPACE NUMBER

COUNTY | STATE | ZIP CODE

INSTRUCTIONS: If you were a fri... r relative, complete Column 1 and 2 for the perio... April 1979 through April 1984.

If you were a spouse, complete Columns 1 and 2 for the period April 1979 through July 1981 ONLY.

Fill in the information in the columns as follows:

Column 1 - Put a check (✓) in the box for each month that you watched out for that person.

Column 2 - For each month you just checked, write the number of hours during that month that you watched the person to prevent harm or injury and were not paid.

REMEMBER: The number of hours each month is the length of time you were home and the person needing your care could be doing something that might get them hurt if left alone.

YEAR/MONTH	COLUMN 1 PROVIDED CARE	COLUMN 2 NUMBER OF HOURS EACH MONTH YOU PROVIDED PROTECTIVE SUPERVISION FOR WHICH YOU WERE NOT PAID
1979 APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		
1980 JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		
1981 JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

YEAR/MONTH	COLUMN 1	COLUMN 2 NUMBER OF HOURS EACH MONTH YOU PROVIDED PROTECTIVE SUPERVISION FOR WHICH YOU WERE NOT PAID
1982 JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		
1983 JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		
1984 JANUARY		
FEBRUARY		
MARCH		
APRIL		

Miller v. Woods
Supplemental Claim Form

INSTRUCTIONS: *Please print. Fill in as much information as you can. If you need help, call or go into your nearest county welfare department office.*

REMEMBER: **You must complete this supplemental claim form and get it to the county welfare within 30 days to get any money.**

1. NAME OF PERSON WHO PROVIDED PROTECTIVE SUPERVISION DURING THE MONTH(S) CLAIMED:

CURRENT ADDRESS: (NUMBER, STREET) APARTMENT/SPACE NUMBER:

CITY: COUNTY: STATE: ZIP CODE:

2. NAME OF PERSON WHO RECEIVED PROTECTIVE SUPERVISION DURING THE MONTH(S) CLAIMED:

CURRENT ADDRESS: (NUMBER, STREET) APARTMENT/SPACE NUMBER:

CITY: COUNTY: STATE: ZIP CODE:

3. Did the person listed in #2 above receive Supplemental Security Income/State Supplemental Program (SSI/SSP) benefits (Gold Check) in any of the following years? Place an X below for each year in which SSI/SSP was received.

☐ 1979 ☐ 1980 ☐ 1981 ☐ 1982 ☐ 1983 ☐ 1984

4. List the average monthly income of the person listed in #2 for the following years:

☐ 1979 ☐ 1980 ☐ 1981 ☐ 1982 ☐ 1983 ☐ 1984

5. Did the person listed in #2 above have average monthly liquid resources (cash, checking or savings account, trust funds, checks or cash in safety deposit box, stocks or bonds, notes, mortgages, deeds) that were in excess of $1500 (if the person was single) or $2250 (if the person was married) during the years April 1979 - April 1984? ☐ Yes ☐ No

If Yes, place an X below the year(s) in which the person's average monthly liquid resources were more than $1500 (if the person was single) or $2250 (if the person was married).

☐ 1979 ☐ 1980 ☐ 1981 ☐ 1982 ☐ [illegible] ☐ 1984

APPLICANT'S STATEMENT:
BE SURE YOU HAVE READ AND ANSWERED ALL THE QUESTIONS ABOVE.
READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING.

☐ I understand that the information I put on this form may be verified and that my signature on this form is an authorization for such an investigation.

☐ I, the undersigned, declare under penalty of perjury that the answers I have given are correct and true to the best of my knowledge.

SIGNATURE OF APPLICANT: DATE

WITNESS' STATEMENT:
Please have the person who can verify that the information you have provided is true and correct sign below.

SIGNATURE OF WITNESS: DATE

ADDRESS: CITY: COUNTY STATE: ZIP CODE:

RELATIONSHIP TO APPLICANT:

RELATIONSHIP TO PERSON WHO RECEIVED PROTECTIVE SUPERVISION:

READ THIS NOTICE: WE MAY OWE YOU MONEY FOR BACK WAGES

WHY ARE YOU GETTING THIS NOTICE?

In a lawsuit called Miller v. Woods, the court has told us to pay back wages to certain relatives, friends and spouses who lived with a mentally ill or confused person and watched out that the person was not harmed or injured doing normal daily activities. We call this "protective supervision." We did not pay for this care from April 1979 to May 1984.

The court said we must pay you with money from the State In-Home Supportive Services (IHSS) Program if you provided protective supervision at any time between April 1979 and May 1984 and were denied payment for that supervision.

If you provided protective supervision after May 1984 and the person was denied IHSS benefits you may also be entitled to back wages if you claim them at the welfare office.

WHAT SHOULD YOU DO?

If you think we owe you money? FILE A CLAIM WITH YOUR COUNTY WELFARE DEPARTMENT NOW. Follow these easy steps:

Fill out the enclosed Miller v. Woods Claim Form.

Take or mail the claim form to your local county welfare department office by March 9, 1989.

If you unsure? FILE A CLAIM ANYWAY. The local county welfare department will decide.

If you want more help or have questions? CALL YOUR LOCAL COUNTY WELFARE DEPARTMENT OR LEGAL AID OFFICE. Ask about the Miller v. Woods case.

REMEMBER: MILLER V. WOODS CLAIMS MUST BE FILED WITH THE COUNTY WELFARE DEPARTMENT BY MARCH 9, 1989 TO GET BACK PAYMENT WAGES.

(7/88)

APPENDIX 2

Legal Aid offices

Alameda County
Legal Aid Society
2357 San Pablo Avenue
Oakland, CA 94612
(415) 465-4376

Alameda County
California Rural
Legal Services
Route 1, Sun Vee Lane
P. O. Box 993
Brawley, CA 92514
(619) 572-3562

Amador County
Legal Services of
Northern California
1122 High Street
Auburn, CA 95603
(800) 822-6107

Butte County
Legal Services of
Northern California
541 Normal Avenue
P. O. Box 3722
Chico, CA 95927
(916) 345-9491

Calaveras County
Legal Services of
Northern California
1122 High Street
Auburn, CA 95603
(800) 822-6107

Colusa County
California Rural Legal
Assistance
816 "D" Street
P. O. Box 2600
Marysville, CA 95901
(916) 742-5191

Contra Costa County
Contra Costa Legal
Services Foundation
1012 Macdonald Avenue
P. O. Box 2189
Richmond, CA 94802
(415) 233-8854

Del Norte County
Redwood Legal Assistance
P. O. Box 1017
100 Third Street
Eureka, CA 95501
(707) 445-0866

El Dorado County
Legal Services of
Northern California
1122 High Street
Auburn, CA 95603
(800) 822-6107

Fresno County
Fresno/Merced Counties
Legal Services
906 "K" Street, Suite 125
Fresno, CA 93721
(209) 441-1611

Glenn County
Legal Services of
Northern California
541 Normal Avenue
P. O. Box 3722
Chico, CA 95927
(916) 345-9491

Humboldt County
Redwood Legal Assistance
P. O. Box 1017
100 Third Street
Eureka, CA 95501
(707) 445-0866

Imperial County
Legal Services
P. O. Box 993
Brawley, CA 92514
(619) 572-3562

Inyo County
California Rural
Legal Assistance
P. O. Box 993
Brawley, CA 92514
(619) 572-3562

Kern County
Tulare/Kings Counties
Legal Services
7 Civic Ave.
Delano, CA 93230
(209) 725-2621

Lake County
Redwood Legal Assistance
P. O. Box 747
Ukiah, CA 95482
(707) 462-1471

Lassen County
Legal Services of
Northern California
1370 West Street
Redding, CA 96001
(800) 822-9687

Los Angeles County
Western Center on
Law and Poverty
AFDC Back Benefits
3535 W. Sixth St., 2nd Floor
Los Angeles, CA 90020
(213) 381-6205

Madera County
California Rural Legal
Assistance
529 South "D" Street
Madera, CA 93638
(209) 674-5671

Marin County
Legal Aid Society
710 "C" Street
San Rafael, CA 94901
(415) 454-8025

Mariposa County
Fresno/Merced Counties
Legal Services
906 "K" Street, Suite 125
Fresno, CA 93721
(209) 441-1611

Mendocino County
Redwood Legal Assistance
P. O. Box 747
Ukiah, CA 95482
(707) 462-1471

Merced County
Fresno/Merced Counties
Legal Services
149 West 16th Street
Merced, CA 95340
(209) 723-6466

Modoc County
Legal Services of
Northern California
1370 West Street
Redding, CA 96001
(800) 822-9687

Mono County
California Indian
Legal Services
Route 1, Sun Vee Lane
P. O. Box 992
Brawley, CA 92514
(619) 572-3562

Monterey County
Legal Aid Society
1011 Cass Street
Monterey, CA 93940
(408) 373-3851

Napa County
Napa County Legal
Assistance Agency
1025 Jellerson Street
Napa, CA 94558
(707) 255-6633

Nevada County
Legal Services of
Northern California
1122 High Street
Auburn, CA 95603
(800) 822-6107

Orange County
Legal Aid Society
2700 N. Main Street,
11th Floor
Santa Ana, CA 92701
(714) 835-6806

Placer County
Legal Services of

Plumas County
Legal Services of
Northern California
541 Normal Avenue
P. O. Box 3722
Chico, CA 95927
(916) 345-9491

Riverside County
Inland Counties Legal
Services
1860 Chicago Ave., #3
Riverside, CA 92507
(714) 682-7741
or
45-550 Greer Street
Indio, CA 92201
(619) 342-1591

Sacramento County
Legal Services of
Northern California
712 — 12th Street
Sacramento, CA 95814
(916) 444-6760

San Benito County
California Rural
Legal Assistance
7872 Elmwood Street
P. O. Box 1566
Gilroy, CA 95020
(408) 847-1405

San Bernardino County
Inland Counties Legal
Services
362 No. Arrowhead Ave.
San Bernardino, CA 92401
(714) 824-2867
or
129 North Euclid
Ontario, CA 91762
(714) 983-0637

San Diego County
Legal Aid Society of
San Diego
110 South Euclid Avenue
San Diego, CA 92114
(619) 262-5557

San Francisco County
San Francisco Neighborhood
Legal Assist. Foundation
49 Powell Street
San Francisco, CA 94102
(415) 677-0200

San Joaquin County
California Rural Legal
Assistance
242 North Sutter, Suite 411
Stockton, CA 95202
(209) 946-0605

San Luis Obispo County
California Rural Legal
Assistance
1100 Tank Street
San Luis Obispo, CA 93401
(805) 544-7994

San Mateo County
Legal Aid Society of
San Mateo County
298 Fuller Street
Redwood City, CA 94063
(415) 365-2555

Santa Barbara County
Channel Counties Legal
Services
725 State St., 2nd Floor
Santa Barbara, CA 93101
(805) 963-5981

Santa Clara County
Legal Aid Society
210 South First Street
San Jose, CA 95113
(408) 998-5200

Shasta County
Legal Services of
Northern California
1370 West Street
Redding, CA 96001
(800) 822-9687

Sierra County
Legal Services of
Northern California
1122 High Street
Auburn, CA 95603
(800) 822-6107

Siskiyou County
Legal Services of
Northern California
1370 West Street
Redding, CA 96001
(800) 822-9687

Solano County
Solano County Legal
Assistance
930 Main Street
Vallejo, CA 94590
(707) 643-0054

Sonoma County
California Rural Legal
Assistance
719 Orchard
P. O. Box 4599
Santa Rosa, CA 95402
(707) 528-9941

Stanislaus County
California Rural Legal
Assistance
1100 Kansas St. Ste. C
Modesto, CA 95351
(209) 577-2811

Sutter County
California Rural Legal
Assistance
816 "D" Street
P. O. Box 2600
Marysville, CA 95901
(916) 742-5191

Tehama County
Legal Services of
Northern California
541 Normal Avenue
P. O. Box 3722
Chico, CA 95927
(916) 345-9491

Trinity County
Legal Services of
Northern California
1370 West Street
Redding, CA 96001
(800) 822-9687

Tulare County
Tulare/Kings Counties
Legal Services
900 West Oak Street
Visalia, CA 93291
(209) 733-8770

Tuolumne County
Fresno/Merced Counties
Legal Services
906 "K" Street, Suite 125
Fresno, CA 93721
(209) 441-1611

Ventura County
Channel Counties Legal
Services
141 South "A" Street
P. O. Box 1222
Oxnard, CA 93032
(805) 487-6521

Yolo County
Legal Services of
Northern California
533 Court Street
Woodland, CA 95695
(916) 447-5798

Yuba County
California Rural Legal

INDEPENDENT LIVING CENTERS

Acult Independence Development
Center of Santa Clara County, Inc.
1190 Benton Street
Santa Clara, CA 95050
Santa Clara County
(408) 985-1243
Cheryl Cairns, Executive Director

C.A.P.H. ILC
1517 East Saginaw Way, Suite 109
Fresno, CA 93704
Fresno County
(209) 222-2274 (Voice)
(209) 222-2396 (TDD)
[illegible], Executive Director

Center for Independence of the
Disabled, Inc.
875 O'Neill Avenue
Belmont, CA 94002
San Mateo County
(415) 595-0723
Lucy Muir, Executive Director

Center for Independent Living
2539 Telegraph Avenue
Berkeley, CA 94704
Alameda County
(415) 841-4776
Michael Winter, Executive Director

Center for Independent Living
San Gabriel/Pomona Valley
2221 East Garvey Avenue
West Covina, CA 91790
Los Angeles County
(818) 339-1278
Denny Meehan, Executive Director

Community Rehabilitation Services
4716 Brooklyn Ave., Bldg. B, Rm. 75
Los Angeles, CA 90022
Los Angeles County
(213) 266-0433
Elsa Quesada, Executive Director

Community Resources for
Independence
915 Piner Road, Suite E
Santa Rosa, CA 95401
Sonoma County
(707) 528-2745
Randy Kitch, Executive Director

Community Resources for Independent
Living, Inc.
25833 Jane Avenue
Hayward, CA 94544
Alameda County
(415) 881-5743
Ms. Johnnie Lacy, Executive Director

Community Service Center for the
Disabled
1295 University Avenue
San Diego, CA 92103
San Diego County
Bill Tainter, Executive Director
(619) 293-3500

Darrell McDaniel Independent Living
Center
14354 Haynes
Van Nuys, CA 91401
Los Angeles County
(818) 986-9825
Norma Vescovo, Executive Director

Dayle McIntosh Center for the
Disabled
8100 Garden Grove Blvd.
Garden Grove, CA 92644
Orange County
(714) 898-9571
(714) 532-1646 (Orange Office)
Brenda Premo, Executive Director

Disabled Resources Center, Inc.
1045 Pine Avenue
Long Beach, CA 90813
Los Angeles County
(213) 437-3543
Helene Pizzini, Executive Director

8/30/85

APPENDIX A-2

INDEPENDENT LIVING CENTERS

Disabilities Unlimited, Inc.
12458 Rives Avenue, Room 202
Downey, CA 90242
Los Angeles County
(213) 862-6631
Barbara Morrione, Executive Director

Good Shepherd Center for
Independent Living
4323 Leimert Blvd.
Los Angeles, CA 90008
Los Angeles County
(213) 295-8366
Gilbert Fernandez, Executive Director

[illegible] Access Project
711 Fourth Street
Eureka, CA 95501
Humboldt County
(707) 445-8404
Donna Janke, Interim Exec. Director

Independent Living Resource
Center
423 W. Victoria
Santa Barbara, CA 93101
Santa Barbara County
(805) 963-1385
Annette Rubino, Executive Director

Marin Center for Independent
Living
710 Fourth Street
San Rafael, CA 94901
Marin County
(415) 485-MCIL (6245) x 320
Barbara Benson, Executive Director

Northern California Independent
Living Center
555 Rio Lindo Ave., Ste. B
Chico, CA 95926
Butte County
(916) 893-8527
Jorganne Cook, Int. Exec. Director

Resources for Independent Living
1230 H Street
Sacramento, CA 95814
Sacramento County
(916) 446-3074
Frances Gracechild, Executive Director

Rolling Start, Inc.
443 West Fourth Street
San Bernardino, CA 92401
San Bernardino County
(714) 884-2129
Don Yigil, Executive Director

Independent Living Resource Center-
San Francisco
4429 Cabrillo Street
San Francisco, CA 94121
San Francisco County
(415) 751-8765
Katherine Uhl, Executive Director

Westside Center for Independent
Living
12901 Venice Blvd.
Los Angeles, CA 90066
Los Angeles County
(213) 390-3611 Voice
(213) 396-8204 TDD
June Kailes, Executive Director

8/30/85

APPENDIX A-3

MULTIPURPOSE SENIOR SERVICES PROGRAM
SITE LOCATIONS

Multipurpose Senior Services Program
City of Oakland
655 14th Street
Oakland, CA 94612
(415) 273-3782

Multipurpose Senior Services Program
County of Santa Cruz
1777-A Capitola Road
Santa Cruz, CA 95062
(408) 425-2540

Multipurpose Senior Services Program
AltaMed
512 South Indiana Street
Los Angeles, CA 90063
(213) 263-2114

Multipurpose Senior Services Program
Jewish Family Service
330 North Fairfax Avenue
Los Angeles, CA 90036
(213) 937-5530

Multipurpose Senior Services Program
S.C.A.N. (Senior Care Action Network)
521 East Fourth Street
Long Beach, CA 90802-2502
(213) 437-6547 or (213) 436-0424

Multipurpose Senior Services Program
Mount Zion Pavilion
2256 Sutter Pavilion, 2nd Floor
San Francisco, CA 94115
(415) 885-7590

Multipurpose Senior Services Program
County of San Diego Area Agency on Aging
4165 Marlborough Avenue
San Diego, CA 92105
(619) 236-[illegible]

Multipurpose Senior Services Program
Community Care Management Corporation
467 North State Street
Ukiah, CA 95482
(707) 468-5347

Multipurpose Senior Services Program
Humboldt Senior Citizens Council
1910 California Street
Eureka, CA 95501

(707) 443-9747

Multipurpose Senior Services Program
Area Agency on Aging
2nd and Normal Streets
California State University
Chico, CA 95929
(916) 895-5082

Multipurpose Senior Services Program
(Sonoma County Area Agency on Aging)
940 Hopper Lane
Santa Rosa, CA 95401
(707) 527-1147

Multipurpose Senior Services Program
(University of California, Davis)
1700 Alhambra Boulevard, Suite 200
Sacramento, CA 95816
(916) 453-5402

Multipurpose Senior Services Program
(County of San Mateo Department of Health Services)
1860 El Camino Real, Suite 222
Burlingame, CA 94010
(415) 692-4500

Multipurpose Senior Services Program
Stanislaus County Department of Social Services
2125 Wylie Drive, Suite 1
Modesto, CA 95355

(209) 571-5752

Multipurpose Senior Services Program
(County of Santa Barbara)
505 West Morrison
Santa Maria, CA 93454

(805) 925-0990

Multipurpose Senior Services Program
Senior Care Network
Huntington Memorial Hospital
557 South Fair Oaks Avenue
Pasadena, CA 91105
(818) 356-3110

Multipurpose Senior Services Program
Senior Home and Health Care
County of San Bernardino
686 East Mill Street
San Bernardino, CA 92415
(714) 387-2434

Multipurpose Senior Services Program
County of Orange Community Services Agency
1300 South Grand, Building B
Santa Ana, CA 92705

(714) 834-6845

Multipurpose Senior Services Program
West Health Foundation, Inc.
2520 Industry Way, Suite D
Lynwood, CA 90262
(213) 603-0934

Multipurpose Senior Services Program
Council on Aging, Santa Clara County, Inc.
2151 The Alameda
San Jose, CA 95126
(408) 296-2290

Multipurpose Senior Services Program
Fresno County Department of Health
1221 Fulton Mall
Fresno, CA 93775
(209) 445-0839

Multipurpose Senior Services Program
San Joaquin County
511 East Magnolia, 3rd Floor
Stockton, CA 95202
(209) 468-3780

* Note: Site names enclosed in parenthesis ( ) are not a part of the site's mailing address.

APPENDIX A-5

JUNE, 1987

CALIFORNIA DEPARTMENT OF AGING
1600 K Street
Sacramento, CA 95814

(916) 323-6601

DIRECTORY OF CALIFORNIA LAW PROJECTS FOR THE ELDERLY

PSA 1 - HUMBOLDT AND DEL NORTE COUNTIES

ROY SCHOENBERG
Senior Citizens Legal Services
1910 California Street
Eureka, CA 95501
(707) 443-9747

PSA 2 - SHASTA, TRINITY, MODOC, LASSEN AND SISKIYOU COUNTIES

THOMAS M. WELSH
Senior Legal Center
P. O. Box 606
3015 South Market Street
Redding, CA 96099
(916) 243-3309

PSA 3 - BUTTE, PLUMAS, TEHAMA, GLENN AND COLUSA COUNTIES

BARRIE ROBERTS
Legal Services of Northern California
P. O. Box 3728
Chico, CA 95927
(916) 345-9491

PSA 4 - PLACER COUNTY

RON ROGERS
Legal Services of No. California, Inc.
Motherlode Branch
190 Reamer
Auburn, CA 95603
(916) 823-7560 - (800) 822-6107

PSA 4 - SACRAMENTO COUNTY

JONATHAN ELLISON
Legal Center for the Elderly and Disabled
330 Bercut Drive, Suite G
Sacramento, CA 95814
(916) 446-1681

PSA 4 - YOLO COUNTY

CAROL GROSSMAN
Legal Center for the Elderly
933 Court Street
Woodland, CA 95695
(916) 662-1065

PSA 4 - YUBA AND SUTTER COUNTIES

SUSAN TOWNSEND
Yuba-Sutter Legal Center
725 "D" Street
Marysville, CA 95901
(916) 742-6285

PSA 5 - MARIN COUNTY

Senior Citizens Legal Project
710 "C" Street
San Rafael, CA 94901
(415) 454-0208

PSA 6 - SAN FRANCISCO COUNTY

ORAH YOUNG
Legal Assistance to the Elderly, Inc.
333 Valencia Street
San Francisco, CA 94103
(415) 861-[illegible]

WILLIAM TAMAYO
Asian Law Caucus
36 Waverly Place, Suite 2
San Francisco, CA 94108
(415) 391-1655

Mailing Address:
WILLIAM TAMAYO
Asian Law Caucus
1322 Webster, Suite 210
Oakland, CA 94612
(415) 835-1474

ILENE GUSFIELD
Mission Community Legal Defense
2940 - 16th Street, Suite 3011
San Francisco, CA 94103
(415) 552-7208

APPENDIX A-6

CALIFORNIA LAW PROJECTS FOR THE ELDERLY

PSA 7 - CONTRA COSTA COUNTY

MARCELINO VASQUEZ
United Council of Spanish Speaking Organizations, Inc.
516 Main Street
Martinez, CA 94553
(415) 229-2210

PSA 8 - SAN MATEO COUNTY

STEVE ZIEFF
Senior Advocates
298 Fuller Street
Redwood City, CA 94063
(415) 365-8411

PSA 9 - ALAMEDA COUNTY

DUNCAN FALLS
Legal Assistance for Seniors
1440 Broadway, Suite 206
Oakland, CA 94612
(415) 832-3040

PSA 10 - SANTA CLARA COUNTY

GEORGIA BACIL
Senior Adults Legal Assistance
160 E. Virginia Street, #250
San Jose, CA 95112
(408) 295-8991

PSA 11 - SAN JOAQUIN COUNTY

JOSE RAMIREZ
Paralegal Services
c/o Council for the Spanish Speaking
142 South Aurora Street
Stockton, CA 95202
(209) 464-4576

PSA 12 - AMADOR COUNTY

JANETH HAGEN
Senior Services, Inc.
229 New York Ranch Road
Jackson, CA 95642
(209) 223-0442

PSA 12 - CALAVERAS COUNTY

FRANK MEYER
California Human Development Corporation
Box 1180
San Andreas, CA 95249
(209) 754-3987

PSA 13 - SANTA CRUZ COUNTY

TERRY HANCOCK
Senior Citizens Legal Services
343 Church Street
Santa Cruz, CA 95060
(408) 426-8824

PSA 14 - FRESNO COUNTY

MICHAEL J. KANZ
Legal Aid for Seniors
906 N Street
Fresno, CA 93721
(209) 441-1611

PSA 15 - TULARE AND KINGS COUNTIES

RANDALL LYONS
Tulare-Kings Counties Legal Services
900 W. Oak Street
Visalia, CA 93277
(209) 733-8770

PSA 16 - INYO AND MONO COUNTIES

LARRY STIDHAM
Senior Citizens Legal Program
See Vee Lane, P. O. Box 993
Bishop, CA 93514
(619) 873-3581

PSA 17 - SAN LUIS OBISPO COUNTY

JOEL DIRINGER
JEANNIE BARRETT
California Rural Legal Assistance
1160 Marsh Street, Suite 204
San Luis Obispo, CA 93401
(805) 544-7994

PSA 17 - SANTA BARBARA COUNTY

DON KUHN
Senior Citizens Law Center
1032 Santa Barbara Street
Santa Barbara, CA 93101
(805) 966-4892

PSA 18 - VENTURA COUNTY

MICHAEL WILLIAMS
Grey Law
40 N. Fir Street
Ventura, CA 93001
(805) 653-0694

Adopt New Section 50-018 to read:

DRAFT

50-018 MILLER v. WOODS 50-018

HANDBOOK BEGINS HERE

.1 Background

These regulations cover the retroactive payment and underpayment relief that must be implemented again. The first phase of the implementation, called Miller I, was from February 11, 1988 to July 19, 1991. The second phase, called Miller II, began on July 19, 1991, the date of the amended judgment. Below is an overview of the case, including the major implementation changes in Miller II from Miller I.

.11 Court of appeal decision: In October of 1983, the Court of Appeal, Fourth Appellate District, invalidated Manual of Policies and Procedures (MPP) Section 30-463.233c (renumber 30-763.233c) in Miller v. Woods, 148 Cal.App.3d 862. It ruled that otherwise eligible In-Home Supportive Services (IHSS) recipients were eligible for protective supervision when it was provided by their housemates. It ordered the State Department of Social Services (SDSS) to grant prospective and retroactive relief to the class.

.12 Initial county welfare department (CWD) case review: On May 1, 1984, SDSS repealed MPP 30-763.233c and adopted MPP 30-763.6, which required CWDs to review their existing IHSS cases and to start paying for protective supervision provided by housemates.

.13 Miller I judgment: On February 11, 1988, the San Diego Superior Court approved a final judgment. SDSS was required to notify potential class members and process claims for back payments to applicants, recipients, and their providers, who had been denied them under the invalidated regulation. There were two kinds of payments: retroactive payments from April 1979 through April 1984, and underpayments from May 1984 on.

.14 Miller I implementation: In September 1988, SDSS adopted regulations (MPP 50-018) and started implementing the judgment. Implementation problems occurred, including the failure to send individual notices to some potential class members, returned notices, delays in sending notices, and insufficient notice of the right to claim underpayments.

.15 Miller I judgment: To correct the implementation problems in Miller I, the Superior Court ordered SDSS to notify potential class members again and process claims for back payments. On July 19, 1991, it approved a final judgment which required certain implementation changes from the first judgment.

.16 Miller II implementation changes: The Miller II regulations are generally similar to the Miller I regulations. There are several important changes based on the implementation problems in Miller I and the court's 1991 amended judgment in Miller II:

.161 Individual notices: SDSS should send individual notices to all providers who lived at the same address as the recipient from January 1, 1980 through November, 1988, including health and community care facilities, if necessary. (MPP 50-018.211)

.162 Updating and remailing returned individual notices: SDSS should update addresses on all individual notices returned as undeliverable until April 1, 1993, and remail any updated. The same deadline, based on the initial 8-month claiming period stipulated in MPP 50-018.23, shall apply.

.163 Reopening late claims: SDSS should reopen and CWDs must process all claims denied solely because they were filed late and issue notices with claim forms to the claimants. (50-018.47)

.164 Retroactive payments: All recipients and non-spouse housemate providers who filed a late claim in Miller I and were denied solely for late filing should have their claim reopened for possible Miller II retroactive payments, for the period from April 1979 through April 1984, by SDSS and processed by CWDs; these individuals need not file another claim for retroactive payments under Miller II (MPP 50-018.47). Any other recipients and non-spouse housemates who provided protective supervision for any time between April 1979 and April 1984, and did not file a Miller I claim, are eligible to file a claim for retroactive payments in Miller II. (MPP 50-018.411, .412). Spouse recipients and providers may file a claim for the limited period from April 1979 to July 1981 in Miller II (MPP 50-018.331), and any claim after July 1981 will be denied under Miller v. Woods and referred to the Welfare Rights Organization (WRO) v. McMahon case. (MPP 50-018.413(b) [to be drafted].)

.165 Underpayments: All non-spouse recipients and providers are eligible to file a claim for underpayments for the period from May 1984 through August 1985. (MPP 50-018.332, .413, .49.) Spouse recipients and providers may not file an underpayment claim in Miller II, and any claim for underpayments will be denied under Miller v. Woods and referred to the WRO v. McMahon case. (MPP 50-018.413(c) [to be drafted])

.166 Eight-month claim period: The claim period in Miller II ~~will~~ should be eight months from the beginning of the mailing of individual notices, and the last day to file claims is September 30, 1993. This date shall apply to remailings as well. (MPP 50-018.23.)

.167 Adverse information notices: CWDs may not deny claims solely because case records or other information contradicts information provided by the claimant on the Standard Claim Form or Supplemental Claim Form. They should send a "Notice of Action for Adverse Information", attaching a copy of relevant information from the case record or other source, and give the claimant 45 days to provide additional information. (MPP 50-018.446, 50-018.463, 50-018.521(a), .522(a), .523(a), and 50-018.633).

.168 Forms: The forms have been changed to reflect the modifications required to implement Miller II, including the use of separate sets of the Standard Claim Form and Supplemental Claim Form for provider claimants and recipient claimants.

(a) Use of Supplemental Claim Form: The CWDs should issue a Supplemental Claim Form to the claimant whenever the CWD is unable to locate either a previously approved IHSS case record or a record of denial. The information from the Supplemental Claim Form, completed as instructed by the County, will be used to examine the claimant's contention that the claimed recipient applied for and/or was denied IHSS during the retroactive claim period, as well as to determine the claimed recipient's income and resource eligibility for IHSS during the period claimed. (MPP 50-018.44,.452.)

(b) If a Miller II claimant is sent a Notice of Action requesting the completion of either the Standard Claim Form or the Supplemental Claim Form, the claimant should have forty-five (45) days from the date of the Notice of Action to complete and mail the postmarked document to the CWD. (MPP 50-018.315, .432)

.169 Notice of Action: For each claim received, the CWD should issue a final Notice of Action for retroactive payments and/or underpayments, which is to contain information specified in MPP 50-018.631(a) through (h).

.170 Monthly CMIPS reports: CMIPS should provide monthly reports on the status of each Miller I claim reopened as a result of being denied due to receipt by the CWD after the end of the Miller I claim period. The reports should contain information specified in MPP 50-018.73.

.171 Related implementation of WRO v. McMahon: CWDs should be implementing relief in WRO v. McMahon at the same time as Miller II. WRO grants spouse recipients and providers back payments for protective supervision and transportation: retroactive payments from July 1, 1983 through September 10, 1984 and underpayments from October 1, 1984 through September 30, 1985. CWDs should treat some Miller II claims for payments under WRO when they extend beyond Miller II claim period for spouses. CWDs should insert a WRO claim form to accompany the Notice of Action for those who are not eligible to receive retroactive payments and/or who apply for underpayments under Miller II, because they are spouse providers. (MPP 50-018.491)

HANDBOOK ENDS HERE

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068.

Adopt New Section 50-018.2 to read:

.2 Notification of Potential Claimants

.21 In order to notify potential claimants, the Department shall:

.211 Send an Explanatory Flyer in English and Spanish, and a Provider Standard Claim Form in English with instructions how to obtain the Spanish version, to all past and present IHSS providers contained on the IHSS Payroll System, from January 1, 1980 to November 30, 1988, who at any time during this period lived at the same address as the recipient. The Department will utilize the services of the Franchise Tax Board and Department of General Services to determine and mail to the most current mailing address available for providers identified in this manner.

.212 Provide each CWD with sufficient quantities of Standard Claim Forms, Supplemental Claim Forms, Explanatory Flyers, and 17" x 22" posters modeled after the Explanatory Flyers. Each of the above documents and posters will be in both English and Spanish.

(a) For Miller II, there shall be a Provider Standard Claim Form, an Applicant/Recipient Standard Claim Form, a Provider Supplemental Claim Form, and an Applicant/Recipient Supplemental Claim Form.

(b) Within these regulations, the terms "Standard Claim Form" and "Supplemental Claim Form" shall apply to both the provider and the applicant/recipient versions of these forms, unless otherwise noted.

(c) In terms of notifying potential claimants as contained in Section 50-018.211, the claim form mailed to providers shall be the Provider Standard Claim Form.

.213 Provide those interested organizations and groups listed in Appendix A-1 through A-9 of the final judgment referred to in Section 50-018.11 with copies of the Standard Claim Forms, the Explanatory Flyers, and the posters, with a request to display the posters in a prominent location and to distribute the Explanatory Flyers and Standard Claim Forms on request throughout the claim period.

.214 Provide the Federal Social Security Administration offices in California with copies of the posters, in English and Spanish, and request the agency to display the posters throughout the claim period in prominent locations where there is public access.

.22 The claim period identified in this section shall be the eight month period from February 1, 1993 through September 30, 1993.

.23 In order to notify potential claimants, the county welfare departments (CWDs) shall:

.231 Place the posters described above in a prominent location in each local office having contact with the public throughout the claim period.

.232 Provide the Explanatory Flyer and Standard Claim Form to any person inquiring about eligibility for retroactive payments and/or underpayments for MILLER v. WOODS.

.24 SDSS shall reopen specific Miller I cases from the first implementation that were denied solely for the reason that the claim was received after the end of the claim period. These reopened cases will be processed by CWDs as MILLER II applications and a determination made following these regulations as to the claimant's eligibility for both retroactive payments and underpayments. Reporting requirements for these reopened cases are contained in Section .73 of these regulations.

.241 The time period for reopened Miller I cases denied because the claim was received after the end of the Miller I claim period, extends from March 10, 1989 through September 30, 1993.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code

Reference: Amended judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068.

Adopt Section 50-018.3 to read:

.3 Application for Retroactive Payments and Underpayments

.31 Claimant Responsibilities

.311 The claimant shall cooperate in obtaining all information necessary to process the claim. Failure to provide the needed information shall result in the denial of the claim or of that portion of the claim for which the information is necessary.

.312 All claims for retroactive payments and underpayments shall be filed on a Miller v. Woods claim form with the county welfare department in which the claimant currently resides.

.313 The claimant shall complete the claim form, sign the form under penalty of perjury, obtain the signature of a witness under penalty of perjury and mail or deliver the completed claim form to the CWD where she/he lives.

.314 The claim form shall be completed as stipulated in Sections 50-018.431 and .443, and hand-delivered or mailed and postmarked to the CWD by September 30, 1993. Claims hand-delivered or mailed and postmarked after this date shall be denied.

.315 If the claimant is sent a Notice of Action requesting the completion of either the Standard Claim Form or the Supplemental Claim Form, the claimant shall have forty-five (45) days from the date of the Notice of Action to complete and hand-deliver or mail the document to the CWD. Whenever the claimant must return a document or documents to the CWD within forty-five (45) days, the following shall apply:

(a) If mailed, the document(s) shall be postmarked by the last day of the forty-five (45) day period.

(b) If hand-delivered, the document(s) shall be delivered to the CWD no later than the close of business on the last day of the forty-five (45) day period.

(c) If required document(s) are not hand-delivered/mailed and postmarked within the time limits stated in this section, denial of the claim, or that portion of the claim for which the information is needed, shall result.

.316 Unless otherwise specified, all references to "days" in regard to time limits shall be construed as "calendar" days.

.32 County Welfare Department Responsibilities - Filing Date

(a) The CWD shall date stamp the claim form when received. The CWD shall retain all claim forms and envelopes of any claims received for the Miller v. Woods lawsuit.

(b) The date of filing shall be the date postmarked on the envelope.

(c) If the claim is filed in person at the CWD, the date of filing shall be the date received in the CWD office, and the date stamped on the claim.

(d) If the filing date cannot be determined as detailed above, the filing date shall be the date the claim was signed.

(e) If the claim must be forwarded to another county for processing because the services were either provided or received in the second county, the first county's filing date shall apply.

(f) If the date of filing on the Standard Claim Form is after September 30, 1993, the claim shall be denied.

(g) If a Supplemental Claim Form, as described in Section 50-018.441, must be sent to the claimant, the filing date shall not change. The filing date shall remain that determined in accordance with Sections 50-018.32(a), (b), (c) and (d).

(h) If the CWD receiving the claim determines that services were received or provided while the recipient/applicant lived in another county, for all or part of the claim period, the CWD shall:

(1) Send a copy of the claim to each affected county. The CWD shall also send a Notice of Action to the claimant within 10 calendar days of the filing date explaining that the correct CWD will process the claim for the period of time in which the services were provided/received in the other county.

(2) As noted in Section 50-018.32(e), the filing date for the claim will be that determined by the first receiving CWD.

(i) If the claim is a reopened Miller I claim, the filing date shall be the date the claim was originally filed under Miller I, in order to be processed for consideration of retroactive payments. The claim for underpayments shall be the date determined by the postmark on the returned claim for underpayments, or as otherwise stipulated in this section.

(j) The CWD shall determine eligibility/ineligibility and compute the retroactive payments and underpayments due within 45 days of the filing date or promptly after all necessary forms have been completed and received by the CWD. The CWD shall input this

information into the Case Management, Information and Payrolling System (CMIPS) so that interest can be computed on approved cases and the computation returned to the CWD.

(1) The CMIPS shall compute the total retroactive payment and/or underpayment amount due, with and without interest and return the computation on a form developed by SDSS to the appropriate CWD within five working days from the date of CWD input.

(k) Within 10 working days of receiving the computation from CMIPS, the CWD shall issue a Notice of Action to the claimant which contains the information specified in Section 50-018.631, and, if applicable, Sections 50-018.634 and .635. If approved, payment is authorized the same day the Notice of Action is authorized.

(l) CWDs receiving claims forwarded from another county shall process the claim, determine eligibility, compute retroactive payments and/or underpayments, compute interest, issue the necessary Notice of Action and input the necessary information into CMIPS within 45 days of receipt from the original county or promptly after all necessary forms are completed.

(m) Time limits for CWDs specified in Section 50-018.32 may be exceeded in situations where completion of the specified tasks is delayed due to circumstances beyond control of the CWD. In these instances, the reason(s) for the delay(s) shall be documented in the affected claimant's case file.

(n) Unless otherwise specified, all references to "days" for these time limits shall be construed as "calendar" days.

.33 Retroactive Payment and Underpayment Time Periods

.331 Eligibility for retroactive payments shall be limited to the following periods:

(a) April 1, 1979 through April 30, 1984 for claims in which the housemate was a nonspouse provider; and,

(b) April 1, 1979 through July 31, 1981 for claims in which the housemate was a spouse provider.

.332 Claims in which the period claimed is beyond the retroactive time period specified in Section 50-018.331(a) shall be processed as underpayments only for the period May 1, 1984 through August 31, 1985.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068.

Adopt Sections 50-018.41, .42, .43, .44, and .45 to read:

.4 Claim Processing

.41 Conditions for Class Membership

.411 IHSS housemate provider claimants may be eligible to receive retroactive payments and/or underpayments in Miller II. Housemate provider claimants who are potentially eligible to receive retroactive payments and/or underpayments are persons who:

(a) Lived with an individual meeting the conditions of Section 50-018.413(a), (b), (c) and (d) and provided protective supervision to that individual during the applicable retroactive payment and/or underpayment period specified in Section 50-018.33; and,

(b) Were not compensated for providing protective supervision services for the month(s) claimed.

.412 Spouse provider claimants may be eligible to receive retroactive payments only and are not entitled to underpayments in Miller II. Spouse provider claimants who are potentially eligible to receive retroactive payments are persons who:

(a) Were legally married to an individual meeting all applicable conditions stated in Section 50-018.413, and provided protective supervision to that individual during the applicable retroactive payment period specified in Section 50-018.331(b); or,

(b) Were considered to be a member of a married couple as defined for the purposes of SSI/SSP eligibility in 20 CFR 416.1806, lived with an individual meeting all applicable conditions stated in Section 50-018.413, and provided protective supervision services during the applicable retroactive payment and/or underpayment period specified in Section 50-018.331(b); and

(c) Were not compensated for providing protective supervision services for the month(s) claimed.

.413 IHSS recipient/applicant claimants potentially eligible to receive retroactive payments and/or underpayments are persons who:

(a) Were California residents, aged, blind, or disabled during the applicable retroactive and/or underpayment period specified in Section 50-018.33 and met the eligibility conditions of MPP 30-755; and,

(b) Were nonself-directing, confused, mentally impaired, or mentally ill, and may have been hurt or injured if left alone, thus meeting the general conditions for requiring the service of protective supervision; and,

(c) Paid the housemate provider during the applicable retroactive payment and/or underpayment period for the service of protective supervision, and either,

(d) Received IHSS benefits, but were denied protective supervision services during the applicable retroactive payment and/or underpayment period solely because the provider was a housemate or a spouse, and the amount of benefits was less than the severely impaired or nonseverely impaired maximum, as applicable at the time; or,

(e) Applied for IHSS services during the applicable retroactive payment and/or underpayment period and were denied protective supervision solely because the provider was a housemate or a spouse.

.42 Review of Class Membership Questions

.421 The CWD shall review the responses to the class membership qualifying questions in Part I, Section 2 of the Provider Standard Claim Form.

(a) If the claimant answered "no" to questions 2A, or 2B, or 2C, or 2D, the CWD shall issue a Notice of Action denying the claim. The notice shall explain that the claimant is not a Miller v. Woods class member.

(b) If the claimant answered "yes" to questions 2A, 2B, 2C, and 2D but answered "no" to both questions in 2F, that is, the person whom the claimant stated received protective supervision neither received nor was denied IHSS benefits, the CWD shall deny the claim and issue a Notice of Action. The notice shall explain that the claimant is not a Miller v. Woods class member because he/she did not prove the claimed recipient applied for or was denied IHSS during the claimed retroactive or underpayment period.

(c) If the claimant answered "yes" to 2A, or 2B, or 2C, or 2D, or 2E, or 2F and the CWD has information available which contradicts the claimant's contention of class membership, the CWD shall issue a Notice of Action for Adverse Information and attach a copy of the contradictory information. The claimant shall have 45 days from the date of Notice of Action to provide additional information if available.

(d) If the claimant answered "unknown" to either part of question 2F of the Provider Standard Claim Form, the CWD shall issue a Notice of Action and a Miller v. Woods Provider Supplemental Claim Form to the claimant. The claimant shall have 45 days from the date of the Notice of Action to complete the form and return it to the CWD.

.43 Review of Information Contained on the Standard Claim Form

.431 The CWD shall review each Standard Claim Form submitted to determine if the claimant has provided the information necessary to further process the claim. For the purposes of this determination, a claim shall be considered complete when all the following requirements are met:

(a) The following information requested in Part I, Section 1 is provided: name, social security number, and current address.

(b) All qualifying questions in Part I, Section 2 are answered.

(c) Part I, Section 3 is completed, if applicable.

(d) Part I, Section 4 is completed in its entirety, including: name of person who needed protective supervision; his/her current or last known address, and his/her relationship to the provider.

(e) Part I, Section 5, of the Standard Claim Form is signed by the claimant and dated.

(f) Part I, Section 6, of the Standard Claim Form is signed and dated.

(g) The information requested in Part II and Part III is provided, as applicable.

.432 If the CWD determines that Part I of the Standard Claim Form has not been completely filled out as specified in Section 50-018.431, or if the claimant and a verifying witness have not signed and dated the form, the CWD shall send the claimant a Notice of Action specifying that portion of the form which is in need of completion. The Notice of Action shall also state that the claimant has 45 days from the date of the Notice of Action to submit the completed form to the CWD. If the completed form is not returned to the CWD within the 45 days, the claim shall be denied, and a denial Notice of Action (NOA) shall be mailed to the claimant.

.433 Upon receipt of the information requested in Section 50-018.432, the CWD shall review the resubmitted information to determine if the claim is now complete in accordance with the criteria in Section 50-018.431. If complete, the CWD shall continue processing the claim.

(a) If the claim is still not complete because the claimant did not provide all the requested information, the CWD shall deny the claim.

.434 Failure on the part of the claimant to respond within the 45-day period shall result in denial of the claim.

.44 Supplemental Claim Form

.441 The CWD shall issue a Supplemental Claim Form to the claimant whenever the CWD is unable to locate either a previously approved IHSS case record or a record of denial of IHSS eligibility. The purpose of the Supplemental Claim Form shall be to: (1) request information from the claimant regarding the claimed recipient's applying for and being denied IHSS during the retroactive payment period; and (2) determine whether the person claimed to have received protective supervision services met or would have met the income/resource eligibility requirements for IHSS services during the period claimed. The CWD shall include a Notice of Action with the Supplemental Claim Form stating that completion of the form is necessary in order to further determine eligibility for retroactive payments and underpayments and that the claimant must return the completed form to the CWD within 45 days.

(a) If the CWD has no case record of an IHSS application and denial for the claimed recipient during the retroactive payment period(s) being claimed, the Notice of Action accompanying the Supplemental Claim Form shall request the claimant to complete all parts of the Supplemental Claim Form, based on the criteria in Section 50-018.443.

(b) If the CWD has a case record showing the claimed recipient had applied for and was denied IHSS for the retroactive payment period(s) being claimed, but the CWD cannot determine from the case record whether the claimed recipient met IHSS income/resource eligibility criteria, the Notice of Action accompanying the Supplemental Claim Form shall request the claimant to complete Parts I, III, and IV of the Supplemental Claim Form, relating to income/resource eligibility for IHSS, based on the criteria in Section 50-018.443.

(c) If the CWD has lost or destroyed its records or did not maintain adequate records during the claimed period, the CWD shall send the Supplemental Claim Form requesting completion of all parts of the form based on the criteria in Section 50-018.443.

.442 Upon receipt the CWD shall date stamp the submitted Supplemental Claim Form following the provisions of Section 50-018.32(a).

.443 The CWD shall review the submitted Supplemental Claim Form to ensure that all required questions are answered, all required information is provided, and that the form is signed and dated by both the claimant and by a verifying witness. For the purposes of this determination, the Supplemental Claim Form shall be considered complete when the required sections specified in Section 50-018.441 are completed and:

(a) The following information requested in Part I, Section 1 is provided: name and address of the person for whom it is claimed provided/received protective supervision services during the months claimed.

(b) For the Provider Supplemental Claim Form, Part I, Section 2, the name and current or last known address of the person for whom it is claimed received protective supervision services during the months claimed, is completed.

(c) If Part II is applicable, Sections 1 and 2 requesting information and documentation related to an IHSS application and/or denial for the person for whom it is claimed received protective supervision services during the months claimed, is completed.

(d) Part III, Sections 1, 2, and 3 relating to the (1) receipt of Supplemental Security Income/State Supplemental Program (SSI/SSP) benefits; (2) average gross monthly income from all sources; and (3) the amount of average monthly liquid resources in excess of $1500 for a single person, and $2250 for a married person, are provided for the claimed recipient during the years for which hours are claimed.

(e) Part IV of the Provider or Recipient Supplemental Claim Form is signed and dated by the claimant.

(f) Part IV, Section 2 of the Provider or Recipient Supplemental Claim Form is signed by a verifying witness, and dated, with his/her address and relationship to claimant completed.

(g) Part IV, Section 3 of the Applicant/Recipient Supplemental Claim Form is signed by the person completing the claim form, with address and relationship to the applicant/recipient completed.

.444 If the CWD determines that the Supplemental Claim Form is incomplete based on the criteria in Section 50-018.443, the CWD shall send a Notice of Action requesting the missing information and attach to he Notice a copy of the original Supplemental Claim Form submitted. The Notice of Action shall specify the section number of the form which is in need of completion and shall state that the claimant has 45 days from the date of the Notice of Action to submit the completed form or the claim will be denied.

(a) Upon receipt of the information requested in Section 50-018.444, the CWD shall review the submitted information to determine whether the Supplemental Claim Form is now complete in accordance with Section 50-018.443. If complete, the CWD shall continue processing the claim. If the Supplemental Claim Form is still not complete, the CWD shall deny the claim.

.445 If the completed Supplemental Claim Form is not received from the claimant within the 45-day limit, the CWD shall deny the claim in accordance with Section 50-018.314.

.446 Information submitted by the claimant on the Supplemental Claim Form shall be presumed to be true as long as the form has been signed and dated by both the claimant and a witness, unless the CWD has information which contradicts information supplied by the claimant. If the CWD has such information available and the CWD determines that information indicates the claimed recipient of protective supervision services would not have been eligible for IHSS, the CWD shall issue a Notice of Action for Adverse Information and attach a copy of the contradictory information. The claimant shall have 45 days from the date of the Notice of Action to provide additional information if available.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068 and 20 CFR 416.1406.

Adopt Section 50-018.45 to read:

.45 Existing Case File and Information Requirement

.451 The CWD shall determine if there is an existing case file with which to match claim information for determining eligibility.

.452 In accordance with Section 50-018.44, if the CWD cannot locate a case file for the IHSS recipient/applicant for whom it is claimed protective supervision services were provided without IHSS compensation, or if the CWD cannot determine eligibility from the existing case file for the months claimed, the CWD shall send a Supplemental Claim Form to the claimant.

.453 All information received and/or obtained in relation to the Miller v. Woods court case, and all forms generated as a result of the court case, shall be retained by the CWD in a MILLER case file. These documents shall include, but not be limited to:

(a) Completed Standard Claim Form and any subsequent resubmittals;

(b) Completed Supplemental Claim Form, if applicable, and any subsequent resubmittals and any documents submitted by the claimant in responding to the Supplemental Claim Form;

(c) Completed Eligibility Determination Worksheets, including documentation of retroactive payments and prejudgment interest calculations as well as underpayment calculations;

(d) A copy of any Notices of Action sent to the claimant;

(e) A copy of any correspondence with other CWDs in relation to the claim;

(f) All CMIPS documents; and,

(g) A copy of all other documents used in the determination of eligibility and computation of payments.

.454 The CWD shall not require the claimant to provide information other than that requested on the Standard Claim Form and, if needed, Supplemental Claim Form. However, the claimant shall be offered an opportunity, in the form of a Notice of Action for Adverse Information, to submit additional information that might rebut a possible denial based on CWD records. The CWD shall consider any additional information submitted by the claimant to support his/her claim.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code

Reference: Amended judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068.

Adopt Section 50-018.46 to read:

.46 Presumptive Need For and Provision of Protective Supervision

.461 If other information available to the CWD, including, but not limited to, previous or current IHSS casefiles, does not rebut the presumption of need for protective supervision, the person claiming to have needed protective supervision is presumed to have needed protective supervision for the months claimed during the applicable retroactive payment and/or underpayment period if:

(a) A need for protective supervision was assessed at any time, in which case the need shall be from that time forward; or,

(b) The needed protective supervision is attested to by a sworn statement from the claimant and verified by a sworn statement of a witness contained on the Standard Claim Form. The CWD shall consider any other documentation submitted by the claimant to support the presumption of need for protective supervision.

.462 The person claiming to have needed protective supervision is presumed to have received protective supervision services for the months claimed during the applicable retroactive payment and underpayment periods if the delivery of such services is attested to by a sworn statement from the claimant and verified by a sworn statement of a witness, contained on the Standard Claim Form, and other information available to the CWD, including, but not limited to, previous or current IHSS casefiles, does not rebut the presumption of delivery of protective supervision services.

(a) The CWD shall presume that any protective supervision services provided and claimed were not provided voluntarily.

.463 If information available to the CWD rebuts the presumption of either the need for or the delivery of protective supervision services during any of the months claimed during the applicable retroactive payment and underpayment period, the CWD shall issue a Notice of Action for Adverse Information and attach a copy of the contradictory information. The claimant shall have 45 days from the date of the Notice of Action to provide additional information if available.

.464 If the CWD IHSS recordkeeping system shows no record of the claimed recipient ever applying for or being denied IHSS for the period being claimed, the CWD shall issue a Notice of Action requesting the claimant to complete an attached Supplemental Claim Form in accordance with Section 50-018.44. The claimant shall have 45 days from the date of the Notice of Action to submit the completed Supplemental Claim Form.

(a) If the claimant does not submit the Supplemental Claim Form within the 45-day period, the claim shall be denied.

(b) If the claimant submits the Supplemental Claim Form, and it is complete based on the criteria in Section 50-018.443, the CWD shall proceed to Section 50-018.532.

(c) If the submitted Supplemental Claim Form is incomplete based on the criteria in Section 50-018.443, the CWD shall follow instructions in Section 50-018.444(a).

(d) If the CWD determines that information supplied by the claimant verifies that the claimed recipient did in fact apply for and was denied IHSS during the retroactive payment period being claimed, the CWD shall continue to process the claim to determine eligibility for payments.

(e) If the CWD determines that the information supplied by the claimant does not verify that the claimed recipient did apply for and was denied IHSS during the retroactive payment period being claimed, the CWD shall issue a denial Notice of Action.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding Miller v. Woods dated July 19, 1991, case no. 472006.

Adopt Section 50-018.47 and .48 to read:

.47 Miller I Reopened Cases Denied For Late Filing

.471 Only those Miller I claims specified in Section 50-018.24 that were denied because the claim was received after the end of the Miller I claim period shall be reopened and reconsidered for retroactive payments and prejudgment interest during the MILLER II claim period.

.472 The Miller I claimants whose claims shall be reopened during Miller II, those claims which were denied solely for the reason of late filing, shall be sent a Notice of Action prior to the beginning of the Miller II claim period. The Notice of Action shall state the reason for the reopening and shall request the claimant to complete an attached Miller II Standard Claim Form only if the claimant desires to make a claim for underpayments.

(a) The claimant will be requested to complete and return the Miller II Standard Claim Form if he/she wishes to make a claim for underpayments.

(b) The CWD shall begin processing the reopened Miller I claims immediately upon notification that the claim has been reopened.

(c) If the Miller I claimant whose case has been reopened makes a claim for underpayments, such claim will be processed in accordance with these regulations.

.48 With the exception of Section 50-018.47 above, claimants filing in Miller II who had previously filed Miller I claims shall have their Miller II claim processed for underpayments only, where underpayments exist.

.481 A Miller I claim shall be one that was received during the Miller I claim period, September 9, 1988 through March 9, 1989. Regulations in effect for Miller I required each claim to receive a retroactive payment eligibility determination resulting in either an approval, a denial, or a partial approval/denial. In addition, the final decision of each Miller I claim had to be documented by a Notice of Action to the claimant stating the decision and notifying the claimant of the right to a state hearing.

.482 No Miller I claim for the retroactive claim period may be reopened or reconsidered except as specified in Section 50-018.47.

.483 Except as specified in Section 50-018.47 above, Miller I claimants who make a claim in Miller II for retroactive payments and prejudgment interest shall have their claim for such payments denied.

.484 Miller I claimants making a claim under the provisions of Miller II for underpayments shall receive an eligibility determination for underpayments.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068.

Adopt Section 50-018.49 to read:

.49 Eligibility for Underpayments

.491 Miller II spouse providers shall not be eligible for underpayments. Spouse provider eligibility for Miller II retroactive payments extends only through July 31, 1981.

(a) Spouse providers making a claim for underpayments in Miller II shall have their underpayment claim denied, with a Notice of Action stating the reason for the denial. Such providers may be eligible for retroactive payments or underpayments under Welfare Rights Organization (WRO) v. McMahon, and will receive a WRO Standard Claim Form with their Miller II denial NOA.

.492 Miller II nonspouse provider and applicant/recipient claims shall be eligible for underpayment consideration only if their eligibility for Miller II retroactive payments extended through the end of the retroactive payment claim period, April 30, 1984.

(a) Nonspouse providers and applicant/recipient claimants shall have their Miller II claim for underpayments denied if their eligibility for retroactive payments does not extend through the end of the Miller II retroactive payment claim period, April 30, 1984. Their Miller II claim for underpayments shall be denied with a Notice of Action stating the reason for the denial.

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(b) Eligibility for underpayments in Miller II results from IHSS cases or Miller II cases carried through the effective date of the corrected housemate regulations, MPP 30-763.6, effective May 1, 1984. Potentially eligible cases are those that were not corrected as of the effective date of the revised regulations. Claims for underpayments in which there was not an active case requiring updating to reflect the housemate regulations shall be denied, with the exception of approved Miller II claimants whose eligibility extends through the end of the retroactive claim period.

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Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code

Reference: Amended Judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068.

Adopt Section 50-018.51, .52, .53, .54, .55, .56, and .57 to read:

.5 Use of County Worksheet to Document Findings and Calculate Payments Due

.51 The CWD shall use the Miller v. Woods Retroactive Payment Eligibility Determination Worksheets to document all determinations made on each claim submitted. Information from the Standard Claim Form, and the Supplemental Claim Form and case record, where available, shall be used to complete the worksheet.

.511 The CWD shall record the claimed provider's and recipient's names, social security numbers, and case number, if available, at the top of Part I of the worksheet.

.512 The CWD shall determine the claimed recipient's eligibility for class membership by reviewing the claimant's response on Part I, Section 2 of the Standard Claim Form, and shall document these findings on step #1 of the worksheet.

(a) If the claimant answered "yes" to questions 2A, 2B, 2C, and 2D, of the Standard Claim Form, the CWD shall proceed to step #2 of the worksheet.

(b) If the claimant answered "no" to any of the above questions, the CWD shall issue a denial Notice of Action explaining that the claimed recipient is not a Miller II class member.

.513 The CWD shall determine if the claimed recipient applied for or was denied IHSS during the retroactive claim period, by reviewing the claimant's response on Part I, Section 2, question 2F, of the Standard Claim Form, and shall document this finding on step #2 of the worksheet.

(a) If the claimant answered "yes" to the first part of question 2F of the Standard Claim Form, the CWD shall proceed to step #3 of the worksheet.

(b) If the claimant answered "no" to the first part of question 2F of the Standard Claim Form, the CWD shall issue a denial Notice of Action.

(c) If the claimant answered "unknown" to either part of question 2F of the Standard Claim Form, the CWD shall send a Supplemental Claim Form to the claimant.

.514 The CWD shall determine if there is any record of an IHSS approval or denial, and shall document this finding on step #3 of the worksheet.

(a) If there is a record of approval or denial the CWD shall:

(1) proceed to step #4 of the worksheet if there is a record of approval for IHSS.

(2) proceed to step #9 of the worksheet if there is a record of denial for IHSS.

(b) If there is no IHSS case record, the CWD shall send the claimant a Supplemental Claim Form.

.52 In determining eligibility for those claims in which the CWD has verified by case record that the claimed recipient of protective supervision services was authorized IHSS during the month(s) claimed, the CWD shall do the following, using the Retroactive Payment Eligibility Determination Worksheet, Part I, steps #4 through #8:

.521 Determine whether the case record indicates that protective supervision services were denied during the month(s) claimed for a reason other than because a spouse/housemate was providing the service, and check the appropriate response on step #4 of the worksheet.

(a) If, for any month(s) claimed, the case record indicates that the denial was based on a reason other than the provision of protective supervision by the spouse/housemate, the CWD shall issue a Notice of Action for Adverse Information and attach a copy of the information which indicates the reason for denial of protective supervision. The claimant shall have 45 days from the date of the Notice of Action to provide additional information if available. The CWD shall process the claim for any remaining month(s) of eligibility, pending receipt of a response from the claimant.

.522 Determine whether any information exists outside the case record which indicates that protective supervision services were denied during the month(s) claimed for any reason other than the provision of protective supervision by the spouse/housemate, and check the appropriate response on step #5 of the worksheet. Information outside the case record may consist of, but not be limited to, the CWD's knowledge of the IHSS recipient's placement in a state hospital or other type of out-of-home care during the month(s) claimed.

(a) If, for any month(s) claimed, information exists outside the case record, as described in Section 50-018.522, the CWD shall document the reason in the space provided on the worksheet, issue a Notice of Action for Adverse Information, and attach a copy of the information, which indicates the reason for denial of protective supervision. The claimant shall have 45 days from the date of the Notice of Action to provide additional information if available.

The CWD shall process the claim for any remaining month(s) of eligibility, pending the receipt of a response from the claimant.

.523 Determine from the case record whether the IHSS recipient was authorized the statutory maximum payment, as described in Section 50-018.58, during any eligible month(s) claimed. Check the appropriate response on step #6 of the worksheet.

(a) For any eligible month(s) claimed in which the IHSS recipient was authorized the statutory maximum payment, the CWD shall issue a Notice of Action of Adverse Information and attach a copy of the relevant information from the case record. The claimant shall have 45 days from the date of the Notice of Action to provide additional information regarding their level of authorized hours, if available.

(b) The CWD shall proceed to Section 50-018.54 and determine if there are any remaining month(s) in which the case was not authorized the statutory maximum.

.524 Determine from the case record or Part I, Section 4 of the Standard Claim Form, the relationship between the claimed provider and recipient. Check the appropriate response on step #7 of the worksheet.

.525 Determine from the case record whether the claimed IHSS recipient was severely impaired (SI) or nonseverely impaired (NSI) and check the appropriate response on step #8 of the worksheet.

.53 In determining eligibility for those claims in which the claimed recipient of protective supervision was denied IHSS during the month(s) claimed, the CWD shall complete step #9 of the Retroactive Payment Eligibility Determination Worksheet, locate the record of denial, and follow the procedures in Sections 50-018.521 and .522. The CWD shall proceed to Section 50-018.55 for instructions to complete the calculation of net payments on Miller II claims in which an IHSS case had been denied and the Miller II claimant is determined eligible for payments.

.531 If the CWD is unable to determine from the record the reason for denial of IHSS during either the entire or partial period claimed, the CWD shall issue a Notice of Action and a Supplemental Claim Form to the claimant to establish whether the claimed recipient received protective supervision would have met the income/resource eligibility requirements for IHSS. The claimant shall have 45 days from the date of the Notice of Action to complete the Supplemental Claim Form and return it to the CWD, or the claim shall be denied.

.532 Upon the CWDs receipt of the completed Supplemental Claim Form, for denied IHSS cases, the CWD shall check the appropriate responses on Part I, steps #10 through #12 of the worksheet. The CWD shall proceed to Section 50-018.55 if:

(a) The claimant's responses on Part III, Sections 2 and 3, of the form indicate that the IHSS income/resource eligibility requirements would have been met during the period claimed.

(b) If the claimant's responses on Part III, Sections 2 and 3, of the form indicate that the IHSS income/resource eligibility requirements would not have been met during the period claimed, the CWD shall deny the claim for those period(s) of ineligibility, document the reason for denial, and then proceed to Section 50-018.55 for any remaining period(s) of eligibility.

(c) If the claimant's responses on Part III, Sections 2 and 3 of the form indicate that the IHSS income/resource eligibility requirements would have been met during the period claimed, but the CWD obtains information which contradicts that supplied by the claimant, the CWD shall issue a Notice of Action For Adverse Information and attach a copy of the contradictory information. The claimant shall have 45 days from the date of the Notice of Action to provide additional information if available.

.533 If the claimant fails to return the completed Supplemental Claim Form to the CWD within 45 days from the date of the Notice of Action, the CWD shall deny those months in which the IHSS eligibility could not be established. If there are any remaining months of potential eligibility, the CWD shall determine eligibility and shall proceed, as applicable, to Section 50-018.55.

.54 Calculating the Actual Retroactive Payments and Underpayments -IHSS Case Record For Period Being Claimed

.541 Parts II and III of the Standard Claim Form and information from the case record, if available, shall be used to calculate retroactive payments and underpayments due on the Retroactive Payment Eligibility Determination Worksheet and the Underpayment Eligibility Determinative Worksheet. The CWD shall use the appropriate worksheet to calculate retroactive payments if the claimant is found eligible.

.542 For each claim in which IHSS eligibility during the applicable retroactive payment and/or underpayment periods has been established by the findings in the case record, the CWD shall use Part II of the appropriate worksheet to calculate and document the payments due for each month as follows:

(a) Each month and year claimed during the retroactive payment and/or underpayment period shall be listed in Column 1.

(b) A determination of whether the claimant is "class eligible," as provided on Part I, step #1 shall be entered for each eligible month in Column 2.

(c) The number of hours claimed, as entered on Parts II and III of the Standard Claim Form, shall be entered in Column 3.

(d) The dollar amount claimed, which shall be determined by multiplying the number of hours claimed by the CWD's lowest individual provider hourly wage rate during the period claimed, shall be calculated by CMIPS in Column 4.

(e) The amount of payment the IHSS recipient was originally authorized during the applicable retroactive and/or underpayment period shall be entered by the CWD, from review of the case record, in Column 5.

(f) The applicable statutory maximum as specified in Section 50-018.58, shall be entered by CMIPS in Column 6.

(1) If the case record indicates that the IHSS recipient was severely impaired, CMIPS shall calculate payments using the applicable severely impaired maximums. If the case record indicates that the IHSS recipient was nonseverely impaired, CMIPS shall calculate payments using the applicable nonseverely impaired maximums. The CWD shall enter the appropriate impairment level in Column 7.

(g) The applicable statutory maximum, as specified in Section 50-018.58 minus the amount originally authorized and entered in Column 5 shall be calculated by CMIPS in Column 8.

(h) Total retroactive payments and/or underpayments due shall be calculated by CMIPS in Column 9 as follows:

(1) For those claims in which it has been established by the case record that the person who is claimed to have received protective supervision services was an IHSS recipient, the total retroactive payments and/or underpayments due shall be the lesser of either of the following:

(A) The difference between the applicable statutory maximum, as specified in Section 50-018.58 and the amount originally authorized, as entered in Column 5, or;

(B) The amount claimed, as entered in Column 4.

(2) Claimants entitled to retroactive payments shall also be entitled to prejudgment interest. CMIPS shall calculate the amount of prejudgment interest due, based on the amount of retroactive payments in Column 9.

(3) Underpayments due shall not be subject to prejudgment interest.

.543 After completion of calculations for retroactive payments and/or underpayments, the CWD claim processor and his/her immediate supervisor shall sign and date the appropriate worksheet at the space provided.

.55 Calculating the Actual Net Retroactive Payments and/or Underpayments -Denied and No Record Cases

.551 Parts II and III of the Standard Claim Form, and the case record and Supplemental Claim Form, if available, shall be utilized to calculate retroactive payments and underpayments due on the Retroactive Payment Eligibility Determination Worksheet and the Underpayment Eligibility Determination Worksheet. The CWD shall use the appropriate worksheet to calculate retroactive payments, if the claimant is found eligible.

.552 For each claim in which the CWD has either located a record of IHSS denial or the CWD has been unable to locate a case record and eligibility for IHSS has been established by the responses on the Supplemental Claim Form, the CWD shall use Part II of the appropriate worksheet to calculate and document the payments due as follows for each month claimed:

(a) Each month and year claimed during the retroactive payment and/or underpayment claim period shall be listed in Column 1.

(b) A determination of whether the claimant is class eligible, as indicated on Part I, step #1, shall be entered for each eligible month in Column 2.

(c) The number of hours claimed, as provided on Parts II and III of the Standard Claim Form, shall be entered in Column 3.

(d) The dollar amount claimed, which shall be determined by multiplying the number of hours claimed by the CWD's lowest individual provider hourly wage rate during the period claimed, shall be calculated by CMIPS in Column 4.

(e) The applicable nonseverely impaired statutory maximum, as specified in Section 50-018.58 shall be calculated by CMIPS in Column 6.

(1) The CWD shall use the applicable nonseverely impaired statutory maximum to calculate payments due for all eligible cases in which: the CWD has no record of denial or the case record could not be located; eligibility has been established through the Supplemental Claim Form; and, available evidence does

not clearly show recipient need at the severely impaired level. The CWD shall enter the appropriate impairment level in Column 7.

(f) The total retroactive payments and/or underpayments due, which shall be the amount claimed, as specified in Section 50-018.542(d), the amount claimed for any month does not exceed the applicable nonseverely impaired statutory maximum during the month claimed shall be calculated by CMIPS in Column 9.

(1) The total payments due shall be limited to the applicable nonseverely impaired statutory maximum amount during the month claimed.

(2) Claimants entitled to retroactive payments shall also be entitled to prejudgment interest.

(3) Underpayments due shall not be subject to prejudgment interest.

.552 After completion of calculations for retroactive payments and/or underpayments, the CWD claim processor and his/her immediate supervisor shall sign and date the appropriate worksheet at the space provided.

.56 The CWD shall use the Miller v. Woods Underpayment Eligibility Determination Worksheet to document all determinations for underpayment claims which were determined eligible for retroactive payments under Miller I or Miller II. Information from the Standard Claim Form, Retroactive Payment Eligibility Determination Worksheet, and Supplemental Claim Form and case record, where available, shall be used to complete the worksheet.

.561 The CWD shall record the claimed provider's and recipient's names, social security numbers, and case number, at the top of Part I.

.562 The CWD shall determine whether the claimant is a spouse by reviewing Part I, Section 4 of the Standard Claim Form.

(a) If the claimant is a spouse, the CWD shall document this on Part I, step #1 of the worksheet, and shall deny the claim for underpayments. The CWD shall refer the claimant to WRO and include a WRO Standard Claim Form with the Miller II denial Notice of Action.

(b) If the claimant is not a spouse, the CWD shall proceed to step #2 of the worksheet.

.563 The CWD shall determine the claimed recipient's eligibility for class membership by reviewing the claimant's response on Part I, Section 2, of the Standard Claim Form, and shall document these findings on step #2 of the worksheet.

(a) If the claimant answered "no" to questions 2A, or B, or C, or D of the Standard Claim Form, the CWD shall issue a denial Notice of Action.

(b) If the claimant answered "yes" to all of the above questions, the CWD shall proceed to step #3 of the worksheet.

.564 The CWD shall review the Standard Claim Form, Part I, Section 2, question 2F to determine if the claimed recipient applied for and/or was denied IHSS during the claim period.

(a) If the claimant answered "no" to the first part of question 2F, the CWD shall issue a denial Notice of Action.

(b) If the claimant answered "yes" to the first part of question 2F, the CWD shall proceed to step #4 of the worksheet.

.565 The CWD shall determine if the claimant filed a claim under Miller I by reviewing the case record or CMIPS.

(a) If the CWD determines the claimant did file a claim under Miller I, the CWD shall proceed to step #5 of the worksheet.

(b) If the CWD determines the claimant did not file a claim under Miller I, the CWD shall proceed to step #7 of the worksheet.

.566 If the claimant filed a claim under Miller I as documented in step #4 of the worksheet, the CWD shall determine if the claim was denied by reviewing the case record or CMIPS.

(a) If the Miller I claim was denied, the CWD shall deny the Miller II underpayment claim.

(b) If the Miller I claim was not denied, the CWD shall proceed to step #6 of the worksheet.

.567 If the claimant filed a claim under Miller I as documented in step #4 of the worksheet, the CWD shall determine if the Miller I claim was approved through the end of the retroactive payment period by reviewing the case record or CMIPS.

(a) If the Miller I claim was approved through the end of the retroactive payment period, the CWD shall proceed to step #9 of the worksheet.

(b) If the Miller I claim was not approved through the end of the retroactive payment period, the CWD shall deny the Miller II underpayment claim.

.568 If the CWD determines the claimant did not file a claim under Miller I, the CWD shall determine if the claimant is eligible for retroactive payments by reviewing the Retroactive Payment Eligibility Determination Worksheet.

(a) If the claimant is not eligible for retroactive payments under Miller II, the CWD shall deny the claim for underpayments.

(b) If the claimant is eligible for retroactive payments under Miller II, the CWD shall determine if the claimant is eligible for retroactive payments through the end of the retroactive payment period, April 30, 1984.

(1) If the claimant is not eligible for retroactive payments through the retroactive period, April 30, 1984, the CWD shall document this on step #8 of the worksheet and deny the claim for underpayments.

(2) If the claimant is eligible for retroactive payments through the end of the retroactive payment period of April 30, 1984, the CWD shall document this on step #8 of the worksheet, and proceed to step #9 of the worksheet.

.569 The CWD shall determine if there is an IHSS case record for the claimant and check the appropriate response on step #9 of the worksheet.

(a) If the CWD determines there is no IHSS case record, the CWD shall compute underpayments at NSI maximums and proceed to Part II of the worksheet.

(b) If the CWD determines there is an IHSS case record, the CWD shall check the appropriate response on step #10 of the worksheet, and calculate underpayments at the appropriate maximums, taking into account payment of previously authorized IHSS services.

.57 Calculating the Actual Underpayments - Claims With and Without an IHSS Case Record

.571 The CWD shall use Section 50-018.54 to calculate underpayments for claims with an IHSS case record, which are otherwise eligible to receive underpayments.

.572 The CWD shall use Section 50-018.55 to calculate underpayments for claims with no IHSS case record, which are otherwise eligible to receive underpayments.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended Judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068; and Sections 12300, 12303.5, 12304, and 12304.5, Welfare and Institutions Code.

Adopt Section 50-018.58 to read:

.58 IHSS Statutory Maximum During Retroactive Payment and Underpayment Periods

Effective Date	NSI	SI
7/1/78 --- 6/30/79	$431	$621
7/1/79 --- 6/30/80	$460	$664
7/1/80 --- 6/30/81	$532	$767
7/1/81 --- 6/30/82	$581	$838
7/1/82 --- 6/30/83	$581	$838
7/1/83 --- 6/30/84	$604	$872
7/1/84 --- 6/30/85	$638	$921
7/1/85 --- 8/31/86	$674	$974

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended Judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068; and Sections 12300, 12303.5, 12304, and 12304.5, Welfare and Institutions Code.

Adopt Section 50-018.61 to read:

.6 General Provisions

.61 Share of cost

.611 The CWD shall not consider any recipient share of cost when computing the amount of retroactive payments and/or underpayments due.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068; and Sections 12300 and 12304.5, Welfare and Institutions Code.

Adopt Section 50-018.62 to read:

.62 Prejudgment Interest

.621 Prejudgment interest for retroactive payments only shall be calculated at the following rates:

(a) Seven percent for the period April 1, 1979 through December 31, 1982; and,

(b) Ten percent for the period January 1, 1983 through April 30, 1984.

.622 The interest shall be computed on the amount of the monthly payment up through the last day of the month following the month in which payment is authorized.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code

Reference: Amended judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068.

Adopt Section 50-018.63 to read:

.63 Notices of Action

.631 For each claim received for retroactive payments and/or underpayments, the CWD shall issue a final Notice of Action. The Notice of Action shall contain the following information:

(a) The month(s) determined eligible and/or ineligible for retroactive payments and/or underpayments. The reason(s) for any months determined ineligible shall be clearly stated;

(b) The amount of retroactive payments due for each month, which shall be shown with and without interest;

(c) The amount of retroactive payments and interest due for each year, if payments are claimed for more than one year;

(d) The total retroactive payments due and the total amount of interest due;

(e) The combined amount of retroactive payments and interest due;

(f) The amount of underpayments due for each month, for each year, if payments are claimed for more than one year, and the total underpayment due;

(g) A statement regarding withholding taxes;

(h) A statement regarding the claimant's right to a State Hearing on Miller v. Woods determinations made by the CWD and information on how to request such hearings.

.632 Each Notice of Action issued due to the claimant's failure to complete either the Standard Claim Form or Supplemental Claim Form in its entirety shall specify those sections of the form in need of completion.

.633 Each Notice of Action issued as a result of the CWD having contradictory information shall include a copy of the information and shall advise the claimant that he/she has 45 days from the date of the Notice of Action to provide additional information, if applicable.

(a) If the claimant does not respond within 45 days and provide information to rebut the CWD's contradictory information, the CWD shall issue a final Notice of Action denying the claim for the months of ineligibility.

.634 For each claim denied, the Notice of Action shall clearly state the reason(s) for denial for each period claimed.

.635 For each approved claim in which the claimant is currently an IHSS recipient, the Notice of Action shall advise the claimant that the payment received as a result of his/her Miller v. Woods claim may adversely affect his/her IHSS, SSI eligibility or other aid program eligibility and tax liability.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068; and Sections 12300 and 12300.2, Welfare and Institutions Code.

Adopt Section 50-018.64 to read:

.64 State Hearings

.641 The right to a state hearing on any Miller v. Woods claim shall be granted only to Miller v. Woods claimants or their authorized representatives.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068; and Sections 10950 and 12300, Welfare and Institutions Code.

Adopt Section 50-018.65 to read:

.65 Treatment of Lump Sum Payments in the IHSS Program

.651 It shall be the responsibility of the CWD to determine if the lump sum Miller v. Woods payments affect or do not affect the continued eligibility of all Miller v. Woods claimants who are currently IHSS recipients.

.652 Miller v. Woods payments shall be disregarded for IHSS financial eligibility determinations for the month of receipt and the following month. Any remaining balance from the Miller v. Woods payments shall be counted as a resource in the second month following the month of receipt.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding Miller v. Woods dated July 19, 1991; case no. 472068.

Adopt New Section 50-018.7 and .8 to read:

.7 Monitoring CWD Compliance

.71 County Statistical Reports

.711 Beginning February 1, 1993 and continuing until an eligibility determination has been made on each claim received, the SDSS shall compile a monthly report on retroactive payment claims and a separate monthly report on underpayment claims. The reports shall contain the following information:

(a) The number of claims received;

(b) The number of claims denied;

(c) The number of claims approved;

(d) The number of claims pending; and,

(e) The amount of payments approved.

.72 Final Report

.721 SDSS shall obtain from the CMIPS a final report, by county, that includes the following:

(a) The number of claimants paid;

(b) The total amount of retroactive payments paid;

(c) The number of underpayments paid; and,

(d) The total amount of underpayments paid.

.73 Beginning with the end of the first month of the claim period, CMIPS will provide a report on the status of each Miller I claim reopened as a result of being denied due to being received by the CWD after the end of the Miller I claim period.

.731 The report shall include, by county, a listing of each reopened claim to include name of recipient, name of claimant, case number, provider number, and NOAs issued to date.

.732 This listing shall be continued until each claim on the listing has been approved or denied.

.733 A final report on the status of these reopened Miller I claims shall be made, to include, by county and statewide: number of Miller I claims reopened, number of approvals, number of denials, total dollar amount retroactive payments, total dollar amount of prejudgment interest, the total of retroactive payments and prejudgment interest, and the total amount of underpayments authorized.

.74 Case Reviews

.741 Based on the quarterly reports, SDSS shall determine the fifteen (15) counties having the largest number of claims over the eight-month period.

.75 County Cooperation

.751 Each CWD shall cooperate with SDSS in providing information deemed necessary to monitor county compliance with the provisions of these regulations and the Miller II final judgment.

.8 Appendix - Forms

.81 The following forms are to be used to process Miller v. Woods claims:

(a) Poster - 2042 (Eng/Sp) (11/92)

(b) Explanatory Flyer - 2031 (Eng/Sp) (11/92)

(c) Provider Standard Claim Form - 2000 (Eng/Sp) (11/92)

(d) Provider Supplemental Claim Form - 2001 (Eng/Sp) (11/92)

(e) Provider Retroactive Eligibility Determination Worksheet - 2003 (Eng/Sp) (11/92)

(f) Provider Underpayment Eligibility Determination Worksheet - 2002 (Eng/Sp) (11/92)

(g) Applicant/Recipient Standard Claim Form - 2028 (Eng/Sp) (11/92)

(h) Applicant/Recipient Supplemental Claim Form - 2029 (Eng/Sp) (11/92)

(i) Applicant/Recipient Eligibility Determination Retroactive Worksheet - 2027 (Eng/Sp) (11/92)

(j) Applicant/Recipient Underpayment Eligibility Determination Worksheet - 2030 (Eng/Sp) (11/92)

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding Miller v. Woods dated July 19, 1991, case no. 472068.

MILLER V. WOODS

APPLICANT/RECIPIENT UNDERPAYMENT ELIGIBILITY DETERMINATION WORKSHEET - PART II

APPLICANT/RECIPIENT'S NAME:	SOCIAL SECURITY NUMBER:

PROVIDER'S NAME:	SOCIAL SECURITY NUMBER:	CASE NUMBER:

INSTRUCTIONS:

Column 1: Enter the month(s) and year(s) the applicant/recipient claims to have paid for protective supervision.

Column 2: Enter yes/no response from Part I, question #3.

Column 3: Fill-in the total number of hours claimed for underpayment of protective supervision, from Part III of the Applicant/Recipient Standard Claim Form.

Column 4: The amount claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 5: From the case record, enter the total number of hours authorized for protective supervision.

Column 6: The statutory maximum for the month(s) being claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required

Column 7: Enter SI/NSI response from Part I, question #10.

Column 8: The statutory maximum minus the amount originally authorized will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 9: The total underpayment due will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7		COLUMN 8	COLUMN 9
Month/Year Claimed	Class Eligible? Yes/No	Hours Claimed	Amount Claimed (Hours claimed x IP Rate During Month Claimed	Amount Originally Authorized	Stat. Max. During Month Claimed	NSI	SI	Stat. Maximum Minus Amount Originally Authorized	Amount Due (Either Column 4 or Column 8 whichever is less)

SIGNATURE OF CLAIM PROCESSOR:	DATE:

SIGNATURE OF SUPERVISOR OR DESIGNEE:	DATE:

LEA ESTA NOTIFICACION
ES POSIBLE QUE EL PROGRAMA DE SERVICIOS DE CASA Y CUIDADO PERSONAL (IHSS) LE DEBA DINERO
¿POR QUE ESTAMOS PAGANDO SALARIOS RETROACTIVOS?

Una orden de la corte nos ordenó pagar salarios retroactivos a ciertas personas en una demanda colectiva llamada Miller vs. Woods porque no pagamos "supervisión con fines de protección" que se les dió a algunas personas de edad avanzada, ciegas o incapacitadas en el Programa de IHSS de abril de 1979 a agosto de 1985. Ya que no se notificó a algunas personas acerca de su derecho de solicitar salarios retroactivos, la corte nos dijo que les diéramos otra oportunidad. A este nuevo esfuerzo se le llama Miller II.

¿REUNE USTED LOS REQUISITOS PARA SALARIOS RETROACTIVOS?

Es posible que usted reúna los requisitos si contesta "sí" a todas las siguientes preguntas con respecto a cualquier tiempo entre abril de 1979 y agosto de 1985:

1. ¿Vivió con, y cuidó de una persona de edad avanzada, ciega o incapacitada en California que haya recibido o solicitado IHSS?
2. ¿No tenía la persona control de sí misma, estaba confundida, tenía impedimentos mentales o enfermedades mentales?
3. ¿Se hubiera lastimado esta persona si se le hubiera dejado sola?
4. ¿Se quedó usted y cuidó de esta persona, para evitar lesiones? (A esto le llamamos "supervisión con fines de protección.")

¿QUE DEBE HACER USTED?

Si usted contesta sí a todas las preguntas anteriores o no está seguro(a):

1. Obtenga la forma de reclamo Miller II de su departamento de bienestar del condado.
2. Entregue la forma de reclamo Miller II a más tardar el 30 de septiembre de 1993 a su departamento de bienestar del condado. Envíela o llévela ahora. Si presenta la forma tarde, usted no recibirá ningún dinero.

¿Necesita ayuda? Llame a su departamento de bienestar del condado u oficina de asistencia legal (Legal Aid) y pregunte acerca del reclamo Miller II.

El plazo final para presentar la forma de reclamo es el 30 de septiembre de 1993. Su forma de reclamo tiene que mostrar esa fecha en el matasellos del correo, o que la reciba el departamento de bienestar del condado a más tardar en esa fecha.

READ THIS NOTICE
THE IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM MAY OWE YOU MONEY
WHY ARE WE PAYING BACK WAGES?

A COURT ORDERED US TO PAY BACK WAGES TO CERTAIN PERSONS IN A LAWSUIT CALLED MILLER V. WOODS BECAUSE WE DID NOT PAY FOR "PROTECTIVE SUPERVISION" GIVEN TO SOME AGED, BLIND OR DISABLED PEOPLE IN THE IHSS PROGRAM FROM APRIL 1979 THROUGH AUGUST 1985. BECAUSE IN 1989 SOME PERSONS WERE NOT NOTIFIED ABOUT THEIR RIGHT TO FILE FOR BACK WAGES, THE COURT TOLD US TO GIVE THEM ANOTHER CHANCE. THIS NEW EFFORT IS CALLED MILLER II.

ARE YOU ELIGIBLE FOR BACK WAGES?

YOU MAY BE ELIGIBLE IF YOU ANSWER "YES" TO ALL OF THE FOLLOWING QUESTIONS FOR ANY TIME FROM APRIL 1979 THROUGH AUGUST 1985:

1. DID YOU LIVE WITH AND CARE FOR AN AGED, BLIND OR DISABLED PERSON IN CALIFORNIA WHO RECEIVED OR APPLIED FOR IHSS?
2. WAS THE PERSON NONSELF-DIRECTING, CONFUSED, MENTALLY IMPAIRED OR MENTALLY ILL?
3. WOULD THE PERSON HAVE BEEN HURT OR INJURED IF LEFT ALONE?
4. DID YOU STAY AND WATCH THE PERSON TO PREVENT INJURIES?(WE CALL THIS PROVIDING "PROTECTIVE SUPERVISION.")

WHAT SHOULD YOU DO?

IF YOU ANSWERED "YES" TO ALL OF THE ABOVE QUESTIONS OR ARE UNSURE:

1. GET THE MILLER II CLAIM FORM FROM YOUR COUNTY WELFARE DEPARTMENT.
2. FILE THE MILLER II CLAIM FORM BY SEPTEMBER 30, 1993 WITH YOUR COUNTY WELFARE DEPARTMENT. MAIL OR TAKE IT IN NOW. IF YOU FILE LATE, YOU WILL NOT GET ANY MONEY.

NEED HELP? CALL YOUR COUNTY WELFARE DEPARTMENT OR LEGAL AID OFFICE AND ASK ABOUT THE MILLER II CLAIM.

THE DEADLINE FOR FILING A CLAIM IS SEPTEMBER 30, 1993. YOUR CLAIM FORM MUST BE POSTMARKED OR RECEIVED BY THE COUNTY WELFARE DEPARTMENT BY THIS DATE.

TEMP 2042 (11/92)

READ THIS NOTICE!
THE IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
MAY OWE YOU MONEY
WHY ARE WE PAYING BACK WAGES?

A court ordered us to pay back wages to certain persons in a lawsuit called Miller v. Woods because we did not pay for "protective supervision" given to some aged, blind or disabled people in the IHSS Program from April 1979 through August 1985. Because in 1989 some persons were not notified about their right to file for back wages, the court told us to give them another chance. This new effort is called Miller II.

ARE YOU ELIGIBLE FOR BACK WAGES?

You may be eligible if you answer "yes" to all of the following questions for any time from April 1979 through August 1985:

1. Did you live with and care for an aged, blind or disabled person in California who received or applied for IHSS?

2. Was the person nonself–directing, confused, mentally impaired or mentally ill?

3. Would the person have been hurt or injured if left alone?

4. Did you stay and watch the person to prevent injuries? (We call this providing "protective supervision.")

WHAT SHOULD YOU DO?

If you answered yes to all of the above questions or are unsure:

1. Fill out the Miller II claim form. You received one with this notice in the mail. Or, you can get one from your county welfare department. If you need a spanish Miller II claim form, please contact the IHSS Section of your county welfare department.

2. File the Miller II claim form by September 30, 1993 with your county welfare department. Mail or take it in now. If you file late, you will not get any money.

Need help? Call your county welfare department or legal aid office and ask about the Miller II claim.

THE DEADLINE FOR FILING A CLAIM IS SEPTEMBER 30, 1993.
YOUR CLAIM FORM MUST BE POSTMARKED OR RECEIVED BY THE COUNTY WELFARE DEPARTMENT BY THIS DATE.

¡LEA ESTE AVISO!

ES POSIBLE QUE EL PROGRAMA DE SERVICIOS DE CASA Y CUIDADO PERSONAL (IHSS) LE DEBA DINERO

¿POR QUE ESTAMOS PAGANDO SALARIOS RETROACTIVOS?

Una corte nos ordenó pagar salarios retroactivos a ciertas personas en una demanda colectiva conocida como Miller vs. Woods porque no pagamos "supervisión con fines de protección" que se le dió a ciertas personas de edad avanzada, ciegas o incapacitadas en el Programa de IHSS, de abril de 1979 a agosto de 1985. Ya que en 1989 a algunas personas no se les notificó acerca de su derecho a solicitar salarios retroactivos, la corte nos dijo que les diéramos otra oportunidad A este esfuerzo se le llama Miller II.

¿REUNE USTED LOS REQUISITOS PARA RECIBIR SALARIOS RETROACTIVOS?

Es posible que usted reúna los requisitos si contesta "sí" a todas las preguntas siguientes, con relación a cualquier tiempo de abril de 1979 a agosto de 1985:

1. ¿Vivió usted con, y cuidó de una persona de edad avanzada, ciega o incapacitada en California que recibía o solicitó IHSS?

2. ¿No tenía esa persona control de sí misma, estaba confundida, o tenía impedimentos o enfermedades mentales?

3. ¿Pudiera haberse lastimado a sí misma esa persona, si se le hubiera dejado sola?

4. ¿Acompañó usted a esa persona para evitar lesiones? (A esto le llamamos "supervisión con fines de protección.")

¿QUE DEBE HACER USTED?

Si contestó sí a todas las preguntas anteriores, o no está seguro(a):

1. Llene la forma de reclamo Miller II. Usted recibió una con esta notificación en el correo, o puede conseguir una en su departamento de bienestar del condado. Si necesita una forma de reclamo de Miller II en español, por favor comuníquese con la Sección de IHSS en su departamento de bienestar del condado.

2. Presente la forma de reclamo Miller II a más tardar el 30 de septiembre de 1993 a su departamento de bienestar del condado. Envíela o llévela ahora. Si la presenta tarde, usted no recibirá ningún dinero.

¿Necesita ayuda? Llame a su departamento de bienestar del condado u oficina de asesoramiento legal *(Legal Aid)* y pídales información con respecto al reclamo Miller II.

LA FECHA TOPE PARA PRESENTAR EL RECLAMO ES EL 30 DE SEPTIEMBRE DE 1993. EL DEPARTAMENTO DE BIENESTAR DEL CONDADO TIENE QUE RECIBIR SU FORMA DE RECLAMO A MAS TARDAR EN ESTA FECHA O EL MATASELLOS DEL CORREO TIENE QUE MOSTRAR ESTA FECHA FINAL.

MILLER V. WOODS
PROVIDER STANDARD CLAIM FORM

INSTRUCTIONS: Please print. This form must be completed to determine if we owe you any money. If you need help completing this, contact the IHSS Section of your county welfare department. Be sure to sign your name in Part I, Section 5 and have someone who knows that you provided protective supervision sign his/her name in Section 6 of Part I.

If you need a spanish Miller II claim form, please contact the IHSS Section of your county welfare department.

REMEMBER: This form must be sent/delivered to the county welfare department by September 30, 1993. If mailed, the envelope must be postmarked by September 30, 1993. If not postmarked or received in the county welfare department by that date, your claim will be denied.

NOTE: Part I of this form asks questions about you and the person who needed protective supervision. Part II asks you for specific information about when protective supervision was actually provided. Part III asks for information about providing protective supervision beyond the Miller v. Woods retroactive payment period.

PART I:

1. YOUR NAME (PRINT): | SOCIAL SECURITY NUMBER: | TELEPHONE NUMBER: ( )

CURRENT ADDRESS (NUMBER, STREET): | APARTMENT/SPACE NUMBER:

CITY: | COUNTY: | STATE: | ZIP CODE:

2. Check the appropriate box for each of the following questions. At any time between the period April 1979 through April 1984:

	YES	NO	UNKNOWN
A. Did you live with a nonself-directing, confused, mentally impaired or mentally ill person who would have been hurt or injured if left alone?	☐	☐	
B. Did you watch this person to make sure he/she did not harm or injure himself/herself?	☐	☐	
C. Was the person who needed to be watched 65 years or older, blind or disabled?	☐	☐	
D. Did the person who needed to be watched live in California?	☐	☐	
E. Were you a relative, spouse or friend of the person who needed to be watched?	☐	☐	
F. Did the person who needed to be watched apply for In-Home Supportive Services (IHSS)?	☐	☐	☐
Was he/she denied IHSS?	☐	☐	☐

3. Your address at the time you provided protective supervision (if different from above)

NUMBER, STREET: | APARTMENT/SPACE NUMBER:

CITY: | COUNTY: | STATE: | ZIP CODE:

4. NAME OF PERSON WHO NEEDED PROTECTIVE SUPERVISION (PRINT): | HIS/HER SOCIAL SECURITY # | TELEPHONE NUMBER: ( )

CURRENT OR LAST KNOWN ADDRESS (NUMBER, STREET): | APARTMENT/SPACE NUMBER:

CITY: | COUNTY: | STATE: | ZIP CODE:

RELATIONSHIP OF THIS PERSON TO YOU:

5. **DECLARATION OF PROVIDER: I understand that the information I have provided above and in Parts II and III on the back of this form is subject to verification by a governmental agency and that my signature on this form is an authorization for such investigation. I, the undersigned, declare under penalty of perjury that the above statements are true and correct.**

SIGNATURE OF PROVIDER: | DATE:

6. **DECLARATION OF WITNESS: I, the undersigned, declare under penalty of perjury that the person named in Section 1 above did live with and provide protective supervision to the person named in Section 4 above.**

NAME OF WITNESS (PRINT): | SIGNATURE OF WITNESS: | DATE:

ADDRESS OF WITNESS (NUMBER, STREET): | APARTMENT/SPACE NUMBER: | TELEPHONE NUMBER: ( )

CITY: | COUNTY: | STATE: | ZIP CODE:

RELATIONSHIP TO PROVIDER: | RELATIONSHIP TO PERSON WHO RECEIVED PROTECTIVE SUPERVISION:

7. **Turn to the back side of this form and read the instructions carefully. Once you have answered all of the questions on both sides of this form, return it to the county welfare department.**

INSTRUCTIONS FOR PARTS II AND III

1. Fill in the total number of hours for each month listed below that you stayed home to provide protective supervision.

2. Protective supervision is for preventing a nonself-directing, confused, mentally impaired or mentally ill person from being harmed or injured.

PART II - CLAIM FOR RETROACTIVE PAYMENTS

(Spouse providers may claim only through July, 1981. For later months, use WRO claim form.)

YEAR/MONTH	NUMBER OF HOURS
1979	
April	
May	
June	
July	
August	
September	
October	
November	
December	
1980	
January	
February	
March	
April	
May	
June	
July	
August	
September	
October	
November	
December	
1981	
January	
February	
March	
April	
May	
June	
July	
August	
September	
October	
November	
December	

YEAR/MONTH	NUMBER OF HOURS
1982	
January	
February	
March	
April	
May	
June	
July	
August	
September	
October	
November	
December	
1983	
January	
February	
March	
April	
May	
June	
July	
August	
September	
October	
November	
December	
1984	
January	
February	
March	
April	

PART III - CLAIM FOR UNDERPAYMENTS

(Spouse providers may not claim underpayments in Miller. Use the WRO claim form.)

YEAR/MONTH	NUMBER OF HOURS
1984	
May	
June	
July	
August	
September	
October	
November	
December	

YEAR/MONTH	NUMBER OF HOURS
1985	
January	
February	
March	
April	
May	
June	
July	
August	

MILLER vs. WOODS
FORMA NORMAL DE RECLAMO PARA PROVEEDORES

INSTRUCCIONES: Por favor escriba con letra de imprenta. Se tiene que completar esta forma para determinar si le debemos dinero. Si necesita asistencia para completarla, comuníquese con la Sección de IHSS del departamento de bienestar de su condado. Asegúrese de firmar en la Parte I, Sección 5, y de pedirle a alguien que sepa que usted proporcionó la supervisión con fines de protección, que firme en la Sección 6 de la Parte I.

RECUERDE: Esta forma tiene que ser enviada/entregada al departamento de bienestar del condado a más tardar el 30 de septiembre de 1993. Si la envía por correo, el sobre tiene que mostrar el matasellos del correo a más tardar del 30 de septiembre de 1993. Se negará su reclamo si no muestra el matasellos del correo a más tardar en esa fecha, o no se recibe en el departamento de bienestar del condado a más tardar en esa fecha.

NOTA: La Parte I de esta forma hace preguntas sobre usted y la persona que necesitó supervisión con fines de protección. La Parte II le pide información específica acerca de cuándo se proveyó en realidad la supervisión con fines de protección. La Parte III pide información acerca de la provisión de supervisión con fines de protección después del período de pagos retroactivos Miller vs.

PARTE I:

1. SU NOMBRE (ESCRIBA CON LETRA DE IMPRENTA): | NUMERO DEL SEGURO SOCIAL: | NUMERO DE TELEFONO: ( )

DIRECCION ACTUAL (NUMERO, CALLE): | NUMERO DE ESPACIO/APARTAMENTO:

CIUDAD: | CONDADO: | ESTADO: | ZONA POSTAL:

2. Marque la casilla pertinente por cada una de las siguientes preguntas. En cualquier momento en el período de abril de 1979 a abril de 1984:

	SI	NO	NO SE
A. ¿Vivió usted con una persona que no tenía control de sí misma, estaba confundida, o tenía impedimentos o enfermedades mentales, o hubiera resultado lesionada si se le hubiera dejado sola?	☐		
B. ¿Cuidó usted de esta persona para asegurar que no se lastimara o lesionara?	☐	☐	
C. ¿Tenía la persona que necesitaba cuidado, 65 años de edad o más, estaba ciega o incapacitada?	☐	☐	
D. ¿Vivía en California la persona que necesitaba cuidado?	☐	☐	
E. ¿Era usted pariente, cónyuge o amistad de la persona que necesita cuidado?	☐	☐	
F. ¿Solicitó la persona que necesitaba cuidado Servicios de Casa y Cuidado Personal (IHSS)?	☐	☐	☐
¿Se le negaron los IHSS?	☐	☐	☐

3. Su dirección en la fecha en que usted proporcionó supervisión con fines de protección (si es diferente de la anterior).

NUMERO, CALLE: | NUMERO DE ESPACIO/APARTAMENTO:

CIUDAD: | CONDADO: | ESTADO: | ZONA POSTAL:

4. NOMBRE DE LA PERSONA QUE NECESITABA SUPERV. CON FINES DE PROTEC. (LETRA DE IMPRENTA): | SU NO. DEL SEGURO SOCIAL: | NUMERO DE TELEFONO: ( )

DIRECCION ACTUAL O ULTIMA DIRECCION CONOCIDA (NUMERO, CALLE): | NUMERO DE ESPACIO/APARTAMENTO:

CIUDAD: | CONDADO: | ESTADO: | ZONA POSTAL:

PARENTESCO DE ESTA PERSONA CON USTED:

5. **DECLARACION DEL PROVEEDOR: Entiendo que la información que he proporcionado arriba y en las Partes II y III en el reverso de esta forma, puede ser verificada por dependencias gubernamentales, y entiendo que mi firma en esta forma es una autorización para que se haga dicha investigación. Yo, el suscrito, declaro bajo pena de perjurio que las declaraciones anteriores son verdaderas y correctas.**

FIRMA DEL PROVEEDOR: | FECHA:

6. **DECLARACION DEL TESTIGO: Yo, el suscrito declaro bajo pena de perjurio que la persona mencionada en la Sección I de arriba vivió con, pagó a, y proveyó supervisión con fines de protección a la persona mencionada en la Sección 4 de arriba.**

NOMBRE DEL TESTIGO (LETRA DE IMPRENTA): | FIRMA DEL TESTIGO: | FECHA:

DIRECCION DEL TESTIGO (NUMERO, CALLE): | NUMERO DE ESPACIO/APARTAMENTO: | NUMERO DE TELEFONO: ( )

CIUDAD: | CONDADO: | ESTADO: | ZONA POSTAL:

PARENTESCO CON EL PROVEEDOR: | PARENTESCO CON LA PERSONA QUE RECIBIO LA SUPERVISION CON FINES DE PROTECCION:

7. **Lea cuidadosamente las instrucciones contenidas en el reverso de esta forma. Una vez que haya contestado <u>todas</u> las preguntas en ambos lados de esta forma, regrésela al departamento de bienestar del condado.**

INSTRUCCIONES PARA LAS PARTES II Y I

1. Anote el número total de horas para cada mes anotado abajo en que usted se quedó en casa para proporcionar supervisión con fines de protección.

2. La supervisión con fines de protección es para evitar que resulte lastimada o lesionada, una persona que no tiene control de sí misma, que está confundida o que tiene impedimentos o enfermedades mentales.

PARTE II - RECLAMO PARA PAGOS RETROACTIVOS

(Los cónyuges proveedores pueden presentar un reclamo solamente hasta julio de 1981. Para meses posteriores, use la forma de

AÑO/MES	NUMERO DE HORAS
1979	
Abril	
Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	
1980	
Enero	
Febrero	
Marzo	
Abril	
Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	
1981	
Enero	
Febrero	
Marzo	
Abril	
Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	

AÑO/MES	NUMERO DE HORAS
1982	
Enero	
Febrero	
Marzo	
Abril	
Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	
1983	
Enero	
Febrero	
Marzo	
Abril	
Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	
1984	
Enero	
Febrero	
Marzo	
Abril	

PARTE III - RECLAMO PARA PAGOS INSUFICIENTES

(Los cónyuges proveedores no pueden reclamar pagos insuficientes bajo Miller. Use la forma de reclamo WRO.)

AÑO/MES	NUMERO DE HORAS
1984	
Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	

AÑO/MES	NUMERO DE HORAS
1985	
Enero	
Febrero	
Marzo	
Abril	
Mayo	
Junio	
Julio	
Agosto	

INSTRUCCIONES PARA LAS PARTES II Y III

1. Columna 1: Complete el número total de horas con respecto a cada mes en que usted proporcionó supervisión con fines de protección.
2. Columna 2: Complete el número total de horas con respecto a cada mes en que usted proporcionó acompañamiento médico.

RECUERDE:
- El número total de horas por concepto de supervisión con fines de protección es la cantidad de tiempo, en cada mes, que usted tuvo que quedarse en casa y cuidar a su esposo(a) para evitar que resultara lastimado o lesionado porque estaba mentalmente enfermo o confundido.
- El número total de horas por concepto de acompañamiento médico es la cantidad de tiempo, en cada mes que usted tuvo que ir y venir a citas médicas con su esposo(a) porque se necesitaba su ayuda. Por favor vea el AVISO EXPLICATIVO WRO vs. MCMAHON para enterarse de los requisitos de elegibilidad.

PARTE II - RECLAMO CON RELACION A BENEFICIOS RETROACTIVOS

INSTRUCCIONES: Por favor complete las columnas 1 y 2 enseguida con relación al período del 1 de julio de 1983 al 30 de septiembre de 1984. Anote la información en las columnas de la manera siguiente:

AÑO/MES	COLUMNA 1: Número de horas reclamadas por proporcionar supervisión con fines de protección:	COLUMNA 2: Número de horas reclamadas por proporcionar acompañamiento médico:
1983		
Julio		
Agosto		
Septiembre		
Octubre		
Noviembre		
Diciembre		
1984		
Enero		
Febrero		
Marzo		
Abril		
Mayo		
Junio		
Julio		
Agosto		
Septiembre		

PARTE III - RECLAMO CON RELACION A PAGOS INSUFICIENTES

INSTRUCCIONES: Si usted continuó proporcionando supervisión con fines de protección y/o acompañamiento médico a su esposo(a) del 1 de octubre de 1984 al 30 de septiembre de 1985, de la manera en que se describe y bajo las condiciones de la manera en que se explican en el Aviso Explicativo WRO vs. MCMAHON, usted puede reclamar salario retroactivo (pago insuficiente) abajo. Por favor siga las instrucciones para las columnas 1 y 2 de la manera en que se explican en la Parte II de arriba.

AÑO/MES	COLUMNA 1: Número de horas reclamadas por proporcionar supervisión con fines de protección:	COLUMNA 2: Número de horas reclamadas por proporcionar acompañamiento médico:
1984		
Octubre		
Noviembre		
Diciembre		
1985		
Enero		
Febrero		
Marzo		
Abril		
Mayo		
Junio		
Julio		
Agosto		
Septiembre		

PARTE IV - ESTABLECIMIENTOS DE TRATAMIENTO MEDICO

INSTRUCCIONES: Por cada mes en que usted reclama haber proporcionado acompañamiento médico más de ocho (8) horas de la manera mencionada en las Partes II y III, columna 2, anote el nombre del profesional o establecimiento de salud, localidad (de la ciudad donde usted vivía a la ciudad donde se encontraba el profesional o establecimiento de salud), clase de transporte que se usó (automóvil, autobús, taxi, otro), mes/año de las visitas, número de visitas mensuales con/a ese profesional o establecimiento de salud y tiempo aproximado que se tomó para completar el viaje redondo.

Nombre del profesional de la Salud/Establecimiento	Localidad De	Localidad A	Clase de Transporte	Mes/Año de las visitas	Número de visitas por mes	Horas por viaje redondo
1.						
2.						
3.						
4.						
5.						

MILLER V. WOODS
PROVIDER SUPPLEMENTAL CLAIM FORM

INSTRUCTIONS: Please print. Fill in all information requested. If you need help, contact the IHSS Section of your county welfare department and ask for assistance.

DEADLINE: **You must complete this supplemental claim form and return it to the county welfare department within 45 days of the date on the Notice of Action.**

PART I

1. NAME OF PERSON WHO PROVIDED PROTECTIVE SUPERVISION DURING THE MONTH(S) CLAIMED (Print):

CURRENT OR LAST KNOWN ADDRESS (NUMBER, STREET):			APARTMENT/SPACE NUMBER:
CITY:	COUNTY:	STATE:	ZIP CODE:

2. NAME OF PERSON WHO RECEIVED PROTECTIVE SUPERVISION DURING THE MONTH(S) CLAIMED (Print):

CURRENT OR LAST KNOWN ADDRESS (NUMBER, STREET):			APARTMENT/SPACE NUMBER:
CITY:	COUNTY:	STATE:	ZIP CODE:

PART II

We have no record of the person you claim to have provided protective supervision ever having applied for and been denied IHSS during the period April 1979 through April 1984. Please complete the following:

1. Do you have other information relating to the IHSS application and denial during the above period for the person you claim to have provided protective supervision? ☐ YES ☐ NO

   If no, proceed to 2.
   If yes, please provide that information in the blanks below:

   A. Who actually applied for IHSS?

   B. Was the application verbal or in writing?

   C. When was the application made?

   D. What services were requested?

2. Do you have any documentation relating to the IHSS application and denial during the above claim period for the months you claim to have provided protective supervision? ☐ YES ☐ NO
   If yes, please attach a copy of all such documentation.

PART III

Please provide the information below for the person you claim to have provided protective supervision services:

1. Did the person listed in Part I, #2 above receive Supplemental Security Income/State Supplemental Program (SSI/SSP) benefits (Gold Check) in any of the following years? Place an X below for each year in which SSI/SSP was received.

   ☐ 1979 ☐ 1980 ☐ 1981 ☐ 1982 ☐ 1983 ☐ 1984

2. List the average gross monthly income from all sources of the person listed in Part I, #2 for the following years: (include income of live-in spouse and/or child, if applicable).

   1979_____ 1980_____ 1981_____
   1982_____ 1983_____ 1984_____

3. Did the person listed in Part I, #2 above have average monthly liquid resources (cash, checking or savings account, trust funds, checks or cash in safety deposit box, stocks or bonds, notes, mortgages, deeds) that were in excess of $1500 (if the person was single) or $2250 (if the person was married) during the years April 1979 - April 1984? ☐ Yes ☐ No

   If Yes, place an X below for the year(s) in which the person's average monthly liquid resources were more than $1500 (if the person was single) or $2250 (if the person was married).

   ☐ 1979 ☐ 1980 ☐ 1981 ☐ 1982 ☐ 1983 ☐ 1984

PART IV

1. **PROVIDER'S STATEMENT:**
   BE SURE YOU HAVE READ AND ANSWERED ALL THE QUESTIONS ABOVE.
   READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING.

   - **I understand that the information I put on this form may be verified and that my signature on this form is an authorization for such an investigation.**
   - **I, the undersigned, declare under penalty of perjury that the answers I have given are correct and true.**

NAME OF PROVIDER (PRINT):	SIGNATURE OF PROVIDER:	DATE:

2. **WITNESS' STATEMENT:**

   I, THE UNDERSIGNED, DECLARE UNDER PENALTY OF PERJURY THAT THE ANSWERS PROVIDED ABOVE BY THE PROVIDER ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

NAME OF WITNESS (PRINT):	SIGNATURE OF WITNESS:			DATE:
ADDRESS:	CITY:	COUNTY:	STATE:	ZIP CODE:

RELATIONSHIP TO PROVIDER:

RELATIONSHIP TO PERSON WHO RECEIVED PROTECTIVE SUPERVISION:

MILLER vs. WOODS
FORMA SUPLEMENTAL DE RECLAMO DEL PROVEEDOR

INSTRUCCIONES: Por favor escriba con letra de imprenta. Anote toda la información que se le pide. Si necesita asistencia, comuníquese con la Sección de IHSS del departamento de bienestar de su condado y pida que le ayuden.

PLAZO: **Usted tiene que completar esta forma suplemental de reclamo y regresarla al departamento de bienestar del condado en un plazo de 45 días contados a partir de la fecha que aparece en la Notificación de Acción.**

PARTE I

1. NOMBRE DE LA PERSONA QUE PROPORCIONO LA SUPERVISION CON FINES DE PROTECCION DURANTE LOS MESES QUE SE RECLAMAN (ESCRIBA CON LETRA DE IMPRENTA):

DIRECCION ACTUAL O ULTIMA DIRECCION DE QUE SE SABE (NUMERO, CALLE):			NUMERO DE ESPACIO/APARTAMENTO:
CIUDAD:	CONDADO:	ESTADO:	ZONA POSTAL:

2. NOMBRE DE LA PERSONA QUE RECIBIO SUPERVISION CON FINES DE PROTECCION DURANTE LOS MESES DEL RECLAMO (ESCRIBA CON LETRA DE IMPRENTA):

DIRECCION ACTUAL O ULTIMA DIRECCION DE QUE SE SABE (NUMERO, CALLE):			NUMERO DE ESPACIO/APARTAMENTO:
CIUDAD:	CONDADO:	ESTADO:	ZONA POSTAL:

PARTE II

No tenemos información acerca de la persona a la que usted dice le proprocionó supervisión con fines de protección, indicando que alguna vez haya solicitado y que se le hayan negado IHSS durante el período de abril de 1979 a abril de 1984. Por favor complete lo siguiente:

1. ¿Tiene usted otra información relacionada a la solicitud para IHSS y la negación durante el período anterior, referente a la persona a la que usted dice le proporcionó supervisión con fines de protección? ☐ SI ☐ NO

   Si no, pase al 2.
   Si sí, por favor anote la información en los espacios en blanco que se proporcionan en seguida:

   A. ¿Quién fue la persona en particular que solicitó IHSS?

   B. ¿Se presentó la solicitud verbalmente o por escrito?

   C. ¿Cuándo se presentó la solicitud?

   D. ¿Qué servicios se solicitaron?

2. ¿Tiene usted cualesquier documentos relacionados a la solicitud de IHSS y a la negación de la misma durante el período de reclamo mencionado arriba con respecto a los meses que usted dice le proporcionó supervisión con fines de protección? ☐ SI ☐ NO
   Si sí, por favor adjunte una copia de dichos documentos.

PARTE III

Por favor anote enseguida la información con respecto a la persona a que usted dice le proporcionó servicios de supervisión con fines de protección:

1. ¿Recibió la persona anotada en la Parte I, #2 de arriba beneficios de Seguridad de Ingreso Suplemental/Programa Suplementario del Estado (SSI/SSP) (cheque dorado) en cualquiera de los años siguientes? Ponga una X enseguida por cada año en que haya recibido SSI/SSP.

   ☐ 1979 ☐ 1980 ☐ 1981 ☐ 1982 ☐ 1983 ☐ 1984

2. Anote los ingresos mensuales brutos promedio provenientes de <u>todas</u> las fuentes, de la persona mencionada en la Parte I, #2 con relación a los siguientes años (incluya ingresos del cónyuge y/o hijo(a) que vivió en el hogar, si es pertinente):

   1979_____ 1980_____ 1981_____
   1982_____ 1983_____ 1984_____

3. ¿Tuvo la persona mencionada en la Parte I, #2 de arriba recursos mensuales promedio convertibles en efectivo (dinero en efectivo, cuenta de cheques o de ahorros, fondos en fideicomiso, cheques o efectivo en una caja de seguridad, acciones o bonos, pagarés, hipotecas, escrituras) que excedían $1,500 (si la persona era soltera) o $2,250 (si la persona era casada) durante los años de abril de 1979 a abril de 1984? ☐ Sí ☐ No

   Si sí, coloque una X enseguida con respecto a cada año en el cual los recursos mensuales promedio convertibles en efectivo de la persona excedían $1,500 (si la persona era soltera) o $2,250 (si la persona era casada).

   ☐ 1979 ☐ 1980 ☐ 1981 ☐ 1982 ☐ 1983 ☐ 1984

PARTE IV

1. **DECLARACION DEL PROVEEDOR:**
   ASEGURESE DE HABER LEIDO Y CONTESTADO TODAS LAS PREGUNTAS ANTERIORES.
   LEA LAS DECLARACIONES SIGUIENTES CUIDADOSAMENTE ANTES DE FIRMAR.

   - **Entiendo que la información que he incluido en esta forma puede ser verificada, y que mi firma en la misma es una autorización para que se haga dicha investigación.**
   - **Yo, el suscrito(a) declaro bajo pena de perjurio que las respuestas que he dado son correctas y verdaderas.**

NOMBRE DEL PROVEEDOR (ESCRIBA CON LETRA DE IMPRENTA):	FIRMA DEL PROVEEDOR:	FECHA:

2. **DECLARACION DEL TESTIGO:**

   YO, EL SUSCRITO(A), DECLARO BAJO PENA DE PERJURIO, QUE LAS RESPUESTAS QUE EL PROVEEDOR DIO ARRIBA SON CORRECTAS Y VERDADERAS SEGUN MI LEAL SABER Y ENTENDER.

NOMBRE DEL TESTIGO (ESCRIBA CON LETRA DE IMPRENTA):	FIRMA DEL TESTIGO:	FECHA:

DIRECCION:	CIUDAD:	CONDADO:	ESTADO:	ZONA POSTAL:

PARENTESCO CON EL PROVEEDOR:

PARENTESCO CON LA PERSONA QUE RECIBIO LA SUPERVISION CON FINES DE PROTECCION:

MILLER V. WOODS

PROVIDER UNDERPAYMENT ELIGIBILITY DETERMINATION WORKSHEET

PART I

PROVIDER'S NAME:	SOCIAL SECURITY NUMBER:

RECIPIENT'S NAME:	SOCIAL SECURITY NUMBER:	CASE NUMBER:

1. Is claimant a spouse? ☐ YES ☐ NO

   If yes, deny underpayment claim, refer claimant to WRO and attach a WRO claim form.
   If no, proceed to #2.

2. Did the claimant answer yes to questions 2A, B, C and D on the Provider Standard Claim Form? ☐ YES ☐ NO

   If no, deny underpayment claim.
   If yes, proceed to #3.

3. Did the claimant answer yes to the first part of question F on the Provider Standard Claim Form? ☐ YES ☐ NO
   (Enter here and Part II, Column 2)

   If no, deny underpayment claim.
   If yes, proceed to #4.
   If unknown, send a Provider Supplemental claim form.

4. Did claimant file for Miller I? ☐ YES ☐ NO

   If yes, proceed to #5.
   If no, proceed to #7.

5. Was Miller I claim denied? ☐ YES ☐ NO

   If yes, deny underpayment claim.
   If no, proceed to #6.

6. Was the Miller I claim approved through the end of the retroactive payment period? ☐ YES ☐ NO

   If yes, proceed to #9.
   If no, deny underpayment claim.

7. Is the claimant eligible for retroactive payments? ☐ YES ☐ NO

   If no, deny underpayment claim.
   If yes, proceed to #8.

8. Is claimant eligible for retroactive payments through the end of the retroactive period (April 1979 through April 1984)? ☐ YES ☐ NO

   If no, deny underpayment claim.
   If yes, proceed to #9.

9. Was there an IHSS case record? ☐ YES ☐ NO

   If no, CMIPS will calculate underpayments using NSI maximums, not to exceed the allowable maximum for any given month, including previously authorized services. Proceed to Part II.

   If yes, proceed to #10.

10. Check (✔) one of the following items: Recipient was ☐ severely impaired (SI) ☐ non-severely impaired (NSI)
    (Enter here and Part II, Column 7)

    If SI, CMIPS will calculate underpayments at the SI maximums.
    If NSI, CMIPS will calculate underpayments at the NSI maximums.
    Proceed to Part II.

MILLER V. WOODS

PROVIDER UNDERPAYMENT ELIGIBILITY DETERMINATION WORKSHEET

PART II

PROVIDER'S NAME:	SOCIAL SECURITY NUMBER:

RECIPIENT'S NAME:	SOCIAL SECURITY NUMBER:	CASE NUMBER:

INSTRUCTIONS:

Column 1: Enter the month(s) and year(s) the provider claims to have provided protective supervision.

Column 2: Enter yes/no response from Part I, question #3.

Column 3: Fill-in the total number of hours claimed for underpayment of protective supervision, from Part III of the Provider Standard Claim Form.

Column 4: The amount claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 5: From the case record, enter the total number of hours authorized for protective supervision.

Column 6: The statutory maximum for the month(s) being claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 7: Enter SI/NSI response from Part I, question #10.

Column 8: The statutory maximum minus the amount originally authorized will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 9: The total underpayment due will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7		COLUMN 8	COLUMN 9
Month/Year Claimed	Class Eligible? Yes/No	Hours Claimed	Amount Claimed (Hours claimed x IP Rate During Month Claimed	Amount Originally Authorized	Stat. Max. During Month Claimed	NSI	SI	Stat. Maximum Minus Amount Originally Authorized	Amount Due (Either Column 4 or Column 8 whichever is less)

SIGNATURE OF CLAIM PROCESSOR:	DATE:

SIGNATURE OF SUPERVISOR OR DESIGNEE:	DATE:

MILLER V. WOODS

PROVIDER RETROACTIVE PAYMENT ELIGIBILITY DETERMINATION WORKSHEET

PART I

PROVIDER'S NAME:		SOCIAL SECURITY NUMBER:
RECIPIENT'S NAME:	**SOCIAL SECURITY NUMBER:**	**CASE NUMBER:**

1. Did the claimant answer yes to Questions 2A, B, C and D on the Provider Standard Claim Form? ..... ☐ YES ☐ NO

   If yes, proceed.

   If no, issue a denial notice.

2. Did claimant answer yes to the first part of question F on the Provider Standard Claim Form?..... ☐ YES ☐ NO
   (Enter response here and Part II, Column 2)

   If yes, proceed.

   If no, issue a denial notice.

   If unknown, try to locate either the case record or the record of denial.

   If neither can be located, send a Provider Supplemental Claim Form.

3. Do you have any record of a denial or approval? ..... ☐ YES ☐ NO

   If yes, proceed to #4 if an approval, or to #9 if a denial.

   If no, send a Provider Supplemental Claim Form.

INSTRUCTIONS: STEPS 4 - 8 ARE TO BE FOLLOWED WHEN IHSS WAS AUTHORIZED DURING THE PERIOD CLAIMED

4. Is there any information in the case record that shows the recipient was denied protective supervision for reason(s) other than provision by a housemate or spouse?..... ☐ YES ☐ NO

   If yes, send a 45-day Adverse Information Notice for months determined ineligible and document the reason(s) for ineligibility in the space below, then proceed to #6 for any remaining months of eligibility.

   Reason(s)_____

   _____

   If no or questionable, proceed to #5.

5. Is there any other information (outside the case record) that shows the recipient was denied protective supervision for reason(s) other than provision by housemate or spouse?..... ☐ YES ☐ NO

   If yes, state the reason(s) on line below and send a 45-day Adverse Information Notice for months determined ineligible and document reason(s) for ineligibility, then proceed to #7 for any remaining months of eligibility.

   Reason(s)_____

   _____

   If no, proceed to #6.

6. Was the case at statutory maximum (stat max) for any month claimed? ..... ☐ YES ☐ NO

   If yes, send 45-day Adverse Information Notice for months in which case was at stat max.

   If no for any month, proceed with months not at stat max.

7. Check (✔) one of the following: Provider was a ☐ Spouse ☐ Relative ☐ Friend

   If provider was a spouse, CMIPS will compute payments at the appropriate rate for eligible months claimed during the period April 1979-July 1981.

   If provider was a relative or friend, CMIPS will compute payments at the appropriate rate for eligible months claimed during the period April 1979-April 1984.

8. Check (✔) one of the following: Recipient was ☐ Severely Impaired (SI) ☐ Nonseverely Impaired (NSI)

   If SI, CMIPS will compute each month using SI maximums not to exceed the allowable maximum for any given month, including costs of previously authorized services.

   If (NSI), CMIPS will compute each month using NSI maximums not to exceed the allowable maximum for any given month, including costs of previously authorized services.

INSTRUCTION: STEP 9 IS TO BE FOLLOWED WHEN IHSS WAS NOT AUTHORIZED DURING THE PERIOD CLAIMED.

9. Was housemate the reason for denial of protective supervision? ..... ☐ YES ☐ NO

   If yes and housemate was a spouse, CMIPS will compute eligibility at NSI maximum for all eligible months claimed within the period April 1979 - July 1981.

   If yes and housemate was a relative or friend, CMIPS will compute eligibility at NSI maximum for all eligible months claimed within the period April 1979 - April 1984.

   If no for any months claimed, document the reason(s) for denial on the line below and send a 45-day Adverse Information Notice.

   Reason(s)_____

   _____

   If unknown, send a Provider Supplemental Claim Form.

INSTRUCTIONS: STEPS 10-12 ARE TO BE FOLLOWED WHEN A COMPLETED PROVIDER SUPPLEMENTAL CLAIM FORM HAS BEEN RECEIVED BY THE CWD.

10. Did the claimant provide information on the Provider Supplemental Claim Form and/or attach documentation that substantiates that protective supervision was applied for and denied during the periods April 1979 - April 1984? ☐ YES ☐ NO

    If yes, proceed to 11.

    If no, proceed to 12.

11. Based on the information provided on the Provider Supplemental Claim Form, did the claimed recipient meet IHSS income/resource eligibility requirements for the months being claimed? ☐ YES ☐ NO

    If yes for any or all months being claimed, CMIPS will calculate payments for all months of eligibility.

    If no for any or all months being claimed, deny the claim for those months.

12. Answer only if #10 is **"NO"**

    Based on the information provided on the Provider Supplemental Claim Form, did the claimed recipient meet IHSS income/resource eligibility requirements for the months being claimed? ☐ YES ☐ NO

    If yes, deny the claim for the reason that the claimed recipient never applied for or was denied IHSS during the months being claimed.

    If no, deny the claim for two reasons:

    (1) the claimed recipient never applied for and was denied IHSS during the months claimed; and

    (2) the claimed recipient did not meet IHSS income/resource eligibility requirements for the months being claimed.

PART II

INSTRUCTIONS:

Column 1: Enter the month(s) and year(s) the provider claims to have provider protective supervision.

Column 2: Enter yes/no response from Part I, question #2.

Column 3: Fill-in the total number of hours claimed for retroactive payment of protective supervision, from Part II of the Provider Standard Claim Form.

Column 4: The amount claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 5: From the case record, enter the total number of hours authorized for protective supervision.

Column 6: The statutory maximum for the month(s) being claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required

Column 7: Enter SI/NSI response from Part I, question #8.

Column 8: The statutory maximum minus the amount originally authorized will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 9: The total retroactive payment due will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7		COLUMN 8	COLUMN 9
Month/Year Claimed	Class Eligible? Yes/No	Hours Claimed	Amount Claimed (Hours claimed x IP Rate During Month Claimed	Amount Originally Authorized	Stat. Max. During Month Claimed	NSI	SI	Stat. Maximum Minus Amount Originally Authorized	Amount Due (Either Column 4 or Column 8 whichever is less)

SIGNATURE OF CLAIM PROCESSOR: DATE:

SIGNATURE OF SUPERVISOR OR DESIGNEE: DATE:

MILLER V. WOODS

PROVIDER RETROACTIVE PAYMENT ELIGIBILITY DETERMINATION WORKSHEET

PART II

PROVIDER'S NAME:	SOCIAL SECURITY NUMBER:

RECIPIENT'S NAME:	SOCIAL SECURITY NUMBER:	CASE NUMBER:

INSTRUCTIONS:

Column 1: Enter the month(s) and year(s) the provider claims to have provided protective supervision.

Column 2: Enter yes/no response from Part I, question #2.

Column 3: Fill-in the total number of hours claimed for retroactive payment of protective supervision, from Part II of the Provider Standard Claim Form.

Column 4: The amount claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 5: From the case record, enter the total number of hours authorized for protective supervision.

Column 6: The statutory maximum for the month(s) being claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required

Column 7: Enter SI/NSI response from Part I, question #8.

Column 8: The statutory maximum minus the amount originally authorized will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 9: The total retroactive payment due will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7		COLUMN 8	COLUMN 9
Month/Year Claimed	Class Eligible? Yes/No	Hours Claimed	Amount Claimed (Hours claimed x IP Rate During Month Claimed)	Amount Originally Authorized	Stat. Max. During Month Claimed	NSI	SI	Stat. Maximum Minus Amount Originally Authorized	Amount Due (Either Column 4 or Column 8 whichever is less)

SIGNATURE OF CLAIM PROCESSOR: DATE:

SIGNATURE OF SUPERVISOR OR DESIGNEE: DATE:

Continue to back as needed.

MILLER V. WOODS

PROVIDER RETROACTIVE PAYMENT ELIGIBILITY DETERMINATION WORKSHEET

PART II

PROVIDER'S NAME:	SOCIAL SECURITY NUMBER:

RECIPIENT'S NAME:	SOCIAL SECURITY NUMBER:	CASE NUMBER:

INSTRUCTIONS:

Column 1: Enter the month(s) and year(s) the provider claims to have provided protective supervision.

Column 2: Enter yes/no response from Part I, question #2.

Column 3: Fill-in the total number of hours claimed for retroactive payment of protective supervision, from Part II of the Provider Standard Claim Form.

Column 4: The amount claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 5: From the case record, enter the total number of hours authorized for protective supervision.

Column 6: The statutory maximum for the month(s) being claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required

Column 7: Enter SI/NSI response from Part I, question #8.

Column 8: The statutory maximum minus the amount originally authorized will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 9: The total retroactive payment due will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7		COLUMN 8	COLUMN 9
Month/Year Claimed	Class Eligible? Yes/No	Hours Claimed	Amount Claimed (Hours claimed x IP Rate During Month Claimed)	Amount Originally Authorized	Stat. Max. During Month Claimed	NSI	SI	Stat. Maximum Minus Amount Originally Authorized	Amount Due (Either Column 4 or Column 8 whichever is less)

SIGNATURE OF CLAIM PROCESSOR:	DATE:
SIGNATURE OF SUPERVISOR OR DESIGNEE:	DATE:

MILLER V. WOODS

APPLICANT/RECIPIENT RETROACTIVE PAYMENT ELIGIBILITY DETERMINATION WORKSHEET

PART I

APPLICANT/RECIPIENT'S NAME:	SOCIAL SECURITY NUMBER:

PROVIDER'S NAME:	SOCIAL SECURITY NUMBER:	CASE NUMBER:

1. Did the claimant answer yes to Questions 2A, B, C and D on the Applicant/Recipient Standard Claim Form? ☐ YES ☐ NO

   If yes, proceed.

   If no, issue a denial notice.

2. Did the claimant answer yes to the first part of question F on the Applicant/Recipient Standard Claim Form? ☐ YES ☐ NO (Enter response here and Part II, Column 2)

   If yes, proceed.
   If no, issue a denial notice.

3. Do you have any record of a denial or approval? ☐ YES ☐ NO

   If yes, proceed to #4 if an approval, or to #9 if a denial.

   If no, send a Applicant/Recipient Supplemental Claim Form.

INSTRUCTIONS: STEPS 4 - 8 ARE TO FOLLOWED WHEN IHSS WAS AUTHORIZED DURING THE PERIOD CLAIMED.

4. Is there any information in the case record that shows applicant/recipient was denied protective supervision for reason(s) other than other than provision by a housemate or spouse? ☐ YES ☐ NO

   If yes, send a 45-day Adverse Information Notice for months determined ineligible and document the reason(s) for ineligibility on the line below, then proceed to #6 for any remaining months of eligibility.

   Reason(s)_____

   _____

   If no or questionable, proceed to #5.

5. Is there any other information (outside the case record) that shows the applicant/recipient was denied protective supervision for reason(s) other than provision by housemate or spouse? ☐ YES ☐ NO

   If yes, state the reason(s) on the line below and send a 45-day Adverse Information Notice for months determined ineligible and document reason(s) for ineligibility, then proceed to #7 for remaining months of eligibility.

   Reason(s)_____

   _____

6. Was the case at statutory maximum (stat max) for any month claimed? ☐ YES ☐ NO

   If yes send a 45-day Adverse Information Notice for months in which case was at stat max..

   If no for any month, proceed with months not at stat max.

7. Check (✔) one of the following: Provider was a ☐ Spouse ☐ Relative ☐ Friend

   If provider was a spouse, CMIPS will compute payments at the appropriate rate for eligible months claimed during the period April 1979 - July 1981.

   If provider was a relative or friend, CMIPS will compute payments at the appropriate rate for eligible months claimed during the period April 1979 - April 1984.

8. Check (✔) one of the following: Recipient was ☐ Severely Impaired (SI) ☐ Nonseverely Impaired (NSI) (Enter response here and Part II, Column 7)

   If SI, CMIPS will compute each month using SI maximums not to exceed the allowable maximum for any given month, including costs of previously authorized services.

   If NSI, CMIPS will compute each month using NSI maximums not to exceed the allowable maximum for any given month, including costs of previously authorized services.

INSTRUCTION: STEP 9 IS TO BE FOLLOWED WHEN IHSS WAS NOT AUTHORIZED DURING THE PERIOD CLAIMED.

9. Was housemate the reason for denial of protective supervision? ☐ YES ☐ NO

   If yes and housemate was a spouse, CMIPS will compute eligibility at NSI maximum for all eligible months claimed within the period April 1979 - July 1981.

   If yes and housemate was a relative or friend, CMIPS will compute eligibility at NSI maximum for all eligible months claimed within the period April 1979 - April 1984.

   If no for any months claimed, document the reason(s) for denial on the line below and send a 45-day Adverse Information Notice.

   Reason(s)_____

   _____

   If unknown, send a Applicant/Recipient Supplemental Claim Form.

INSTRUCTIONS: STEPS 10-12 ARE TO BE FOLLOWED WHEN A COMPLETED APPLICANT/RECIPIENT SUPPLEMENTAL CLAIM FORM HAS BEEN RECEIVED BY THE CWD

10. Did the claimant provide information on the Applicant/Recipient Supplemental Claim Form and/or attach documentation that substantiates the claimed recipient of protective supervision applied for and was denied IHSS during the periods April 1979 through April 1984? ..... ☐ YES ☐ NO

    If yes, proceed to 11.

    If no, proceed to 12.

11. Based on the information provided on the Applicant/Recipient Supplemental Claim Form, did the claimed recipient meet IHSS income/resource eligibility requirements for the months being claimed? ..... ☐ YES ☐ NO

    If yes for any or all months being claimed, CMIPS will calculate payments for all months of eligibility.
    If no for any or all months being claimed, deny the claim for those months.

12. **Answer only if #10 is "NO"**

    Based on the information provided on the Applicant/Recipient Supplemental Claim Form, did the claimed recipient meet IHSS income/resource eligibility requirements for the months being claimed? ..... ☐ YES ☐ NO

    If yes, deny the claim for the reason that the claimed recipient never applied for or was denied IHSS during the months being claimed.

    If no, deny the claim for two reasons:

    (1) the claimed recipient never applied for and was denied IHSS during the months claimed; and

    (2) the claimed recipient did not meet IHSS income/resource eligibility requirements for the months being claimed.

PART II

INSTRUCTIONS:

Column 1: Enter the month(s) and year(s) the applicant/recipient claims to have paid for protective supervision.

Column 2: Enter yes/no response from Part I, question #2.

Column 3: Fill-in the total number of hours claimed for protective supervision, from Part II of the Applicant/Recipient Standard Claim Form.

Column 4: The amount claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 5: From the case record, enter the total number of hours authorized for protective supervision.

Column 6: The statutory maximum for the month(s) being claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required

Column 7: Enter SI/NSI response from Part I, question #8

Column 8: The statutory maximum minus the amount originally authorized will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 9: The total payment amount due will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7		COLUMN 8	COLUMN 9
Month/Year Claimed	Class Eligible? Yes/No	Hours Claimed	Amount Claimed (Hours claimed x IP Rate During Month Claimed	Amount Originally Authorized	Stat. Max. During Month Claimed	NSI	SI	Stat. Maximum Minus Amount Originally Authorized	Amount Due (Either Column 4 or Column 8 whichever is less)

SIGNATURE OF CLAIM PROCESSOR: DATE:

SIGNATURE OF SUPERVISOR OR DESIGNEE: DATE:

MILLER V. WOODS

APPLICANT/RECIPIENT RETROACTIVE BENEFIT ELIGIBILITY DETERMINATION WORKSHEET

PART II

APPLICANT/RECIPIENT'S NAME:		SOCIAL SECURITY NUMBER:
PROVIDER'S NAME:	SOCIAL SECURITY NUMBER:	CASE NUMBER:

INSTRUCTIONS:

Column 1: Enter the month(s) and year(s) the applicant/recipient claims to have paid for protective supervision.

Column 2: Enter yes/no response from Part I, question #2.

Column 3: Fill-in the total number of hours claimed for protective supervision, from Part II of the Applicant/Recipient **Standard Claim** Form.

Column 4: The amount claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 5: From the case record, enter the total number of hours authorized for protective supervision.

Column 6: The statutory maximum for the month(s) being claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required

Column 7: Enter SI/NSI response from Part I, question #8

Column 8: The statutory maximum minus the amount originally authorized will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 9: The total payment amount due will be calculated by CMIPS and displayed on a turn-around document. **No manual entry** is required.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7		COLUMN 8	COLUMN 9
Month/Year Claimed	Class Eligible? Yes/No	Hours Claimed	Amount Claimed (Hours claimed x IP Rate During Month Claimed)	Amount Originally Authorized	Stat. Max. During Month Claimed	NSI	SI	Stat. Maximum Minus Amount Originally Authorized	**Amount Due** (Either **Column 4 or Column 8 whichever is less**)

SIGNATURE OF CLAIM PROCESSOR: DATE:

SIGNATURE OF SUPERVISOR OR DESIGNEE: DATE:

Continue to back as needed.

MILLER V. WOODS

APPLICANT/RECIPIENT RETROACTIVE BENEFIT ELIGIBILITY DETERMINATION WORKSHEET

PART II

APPLICANT/RECIPIENT'S NAME:		SOCIAL SECURITY NUMBER:
PROVIDER'S NAME:	SOCIAL SECURITY NUMBER:	CASE NUMBER:

INSTRUCTIONS:

Column 1: Enter the month(s) and year(s) the applicant/recipient claims to have paid for protective supervision.

Column 2: Enter yes/no response from Part I, question #2.

Column 3: Fill-in the total number of hours claimed for protective supervision, from Part II of the Applicant/Recipient Standard Claim Form.

Column 4: The amount claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 5: From the case record, enter the total number of hours authorized for protective supervision.

Column 6: The statutory maximum for the month(s) being claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required

Column 7: Enter SI/NSI response from Part I, question #8

Column 8: The statutory maximum minus the amount originally authorized will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

Column 9: The total payment amount due will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7		COLUMN 8	COLUMN 9
Month/Year Claimed	Class Eligible? Yes/No	Hours Claimed	Amount Claimed (Hours claimed x IP Rate During Month Claimed)	Amount Originally Authorized	Stat. Max. During Month Claimed	NSI	SI	Stat. Maximum Minus Amount Originally Authorized	Amount Due (Either Column 4 or Column 8 whichever is less)

SIGNATURE OF CLAIM PROCESSOR:	DATE:
SIGNATURE OF SUPERVISOR OR DESIGNEE:	DATE:

MILLER V. WOODS
APPLICANT/RECIPIENT STANDARD CLAIM FORM

INSTRUCTIONS: Please print. This form must be completed to determine if we owe you any money. If you need help completing this, contact the IHSS Section of your county welfare department. Be sure to sign your name in Part I, Section 5 and have someone who knows that you paid for the service of protective supervision sign his/her name in Section 6 of Part I.

If you need a Spanish Miller II claim form, please contact the IHSS section of your county welfare department.

REMEMBER: This form must be sent/delivered to the county welfare department by September 30, 1993. If mailed, the envelope must be postmarked by September 30, 1993. If not postmarked or received in the county welfare department by that date, your claim will be denied.

NOTE: Part I of this form asks questions about you and the person who you paid to provide protective supervision to you. Part II asks you for specific information about when protective supervision was actually provided. Part III asks for information about your paying for and receiving protective supervision beyond the Miller v. Woods retroactive payment period.

PART I:

1. NAME OF APPLICANT/RECIPIENT (PRINT): | SOCIAL SECURITY NUMBER: | TELEPHONE NUMBER: ( )

CURRENT ADDRESS (NUMBER, STREET): | APARTMENT/SPACE NUMBER:

CITY: | COUNTY: | STATE: | ZIP CODE:

2. Check the appropriate box for each of the following questions. Between the period April 1979 through April 1984:

	YES	NO
A. Were you a nonself-directing, confused, mentally impaired or mentally ill person who would have been hurt or injured if left alone?	☐	☐
B. Did you pay someone to watch you to make sure you did not harm or injure yourself?	☐	☐
C. Were you 65 years or older, blind or disabled?	☐	☐
D. Did you live in California?	☐	☐
E. Was the person who you paid to watch you a relative, spouse or a friend?	☐	☐
F. Did you apply for In-Home Supportive Services (IHSS)?	☐	☐
Were you denied IHSS?	☐	☐

3. Your address at the time you paid for and received protective supervision (if different from above)

NUMBER, STREET: | APARTMENT/SPACE NUMBER:

CITY: | COUNTY: | STATE: | ZIP CODE:

4. NAME OF PERSON WHO PROVIDED PROTECTIVE SUPERVISION TO YOU(PRINT): | HIS/HER SOCIAL SECURITY # | TELEPHONE NUMBER: ( )

CURRENT OR LAST KNOWN ADDRESS (NUMBER, STREET): | APARTMENT/SPACE NUMBER:

CITY: | COUNTY: | STATE: | ZIP CODE:

RELATIONSHIP OF THIS PERSON TO YOU:

5. **DECLARATION OF APPLICANT/RECIPIENT: I understand that the information I have provided above and in Parts II and III on the back of this form is subject to verification by a governmental agency and that my signature on this form is an authorization for such investigation. I, the undersigned, declare under penalty of perjury that the above statements are true and correct.**

SIGNATURE OF APPLICANT/RECIPIENT: | DATE:

6. **DECLARATION OF WITNESS: I, the undersigned, declare under penalty of perjury that the person named in Section 1 above did live with, pay for, and receive protective supervision from the person named in Section 4 above.**

NAME OF WITNESS (PRINT): | SIGNATURE OF WITNESS: | DATE:

ADDRESS OF WITNESS (NUMBER, STREET): | APARTMENT/SPACE NUMBER: | TELEPHONE NO.: ( )

CITY: | COUNTY: | STATE: | ZIP CODE:

RELATIONSHIP TO APPLICANT/RECIPIENT: | RELATIONSHIP TO PERSON WHO PROVIDED PROTECTIVE SUPERVISION:

7. NAME OF PERSON COMPLETING THIS FORM FOR THE APPLICANT/RECIPIENT (PRINT):

ADDRESS (NUMBER, STREET): | APARTMENT/SPACE NUMBER: | TELEPHONE: ( )

CITY: | COUNTY: | STATE: | ZIP CODE:

SIGNATURE: | RELATIONSHIP TO APPLICANT/RECIPIENT:

8. **Turn to the back side of this form and read the instructions carefully. Once you have answered all of the questions on both sides of this form, return it to the county welfare department.**

INSTRUCTIONS FOR PARTS II AND III

1. Fill in the total number of hours for each month listed below that you paid for and received protective supervision.

2. Protective supervision is for preventing a nonself-directing, confused, mentally impaired or mentally ill person from being harmed or injured.

PART II - CLAIM FOR RETROACTIVE PAYMENTS

(Spouse recipients may claim only through July, 1981. For later months, use WRO claim form.)

YEAR/MONTH	NUMBER OF HOURS
1979	
April	
May	
June	
July	
August	
September	
October	
November	
December	
1980	
January	
February	
March	
April	
May	
June	
July	
August	
September	
October	
November	
December	
1981	
January	
February	
March	
April	
May	
June	
July	
August	
September	
October	
November	
December	

YEAR/MONTH	NUMBER OF HOURS
1982	
January	
February	
March	
April	
May	
June	
July	
August	
September	
October	
November	
December	
1983	
January	
February	
March	
April	
May	
June	
July	
August	
September	
October	
November	
December	
1984	
January	
February	
March	
April	

PART III - CLAIM FOR UNDERPAYMENTS

(Spouse recipients may not claim underpayments in Miller. Use the WRO claim form.)

YEAR/MONTH	NUMBER OF HOURS
1984	
May	
June	
July	
August	
September	
October	
November	
December	

YEAR/MONTH	NUMBER OF HOURS
1985	
January	
February	
March	
April	
May	
June	
July	
August	

INSTRUCCIONES PARA LAS PARTES II Y

1. Anote el número total de horas para cada mes anotado abajo en que usted se quedó en casa para proporcionar supervisión con fines de protección.

2. La supervisión con fines de protección es para evitar que resulte lastimada o lesionada, una persona que no tiene control de sí misma, que está confundida o que tiene impedimentos o enfermedades mentales.

PARTE II - RECLAMO PARA PAGOS RETROACTIVOS

(Los cónyuges proveedores pueden presentar un reclamo solamente hasta julio de 1981. Para meses posteriores, use la forma de

AÑO/MES	NUMERO DE HORAS
1979	
Abril	
Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	
1980	
Enero	
Febrero	
Marzo	
Abril	
Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	
1981	
Enero	
Febrero	
Marzo	
Abril	
Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	

AÑO/MES	NUMERO DE HORAS
1982	
Enero	
Febrero	
Marzo	
Abril	
Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	
1983	
Enero	
Febrero	
Marzo	
Abril	
Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	
1984	
Enero	
Febrero	
Marzo	
Abril	

PARTE III - RECLAMO PARA PAGOS INSUFICIENTES

(Los cónyuges proveedores no pueden reclamar pagos insuficientes bajo Miller. Use la forma de reclamo WBQ.)

AÑO/MES	NUMERO DE HORAS
1984	
Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	

AÑO/MES	NUMERO DE HORAS
1985	
Enero	
Febrero	
Marzo	
Abril	
Mayo	
Junio	
Julio	
Agosto	

MILLER vs. WOODS
FORMA NORMAL DE RECLAMO PARA SOLICITANTES/BENEFICIARIOS

INSTRUCCIONES: Por favor escriba con letra de imprenta. Se tiene que completar esta forma para determinar si le debemos dinero. Si necesita asistencia para completarla, comuníquese con la Sección de IHSS del departamento de bienestar de su condado. Asegúrese de firmar en la parte I, Sección 5, y de pedirle a alguien que sepa que usted pagó servicios de supervisión con fines de protección, que firme en la Sección 6 de la Parte I.

RECUERDE: Esta forma tiene que ser enviada/entregada al departamento de bienestar del condado a más tardar el 30 de septiembre de 1993. Si la envía por correo, el sobre tiene que mostrar el matasellos del correo a más tardar el 30 de septiembre de 1993. Se negará su reclamo si no muestra el matasellos del correo a más tardar en esa fecha, o no se recibe a más tardar en esa fecha.

NOTA: La Parte I de esta forma hace preguntas sobre usted y la persona a la que usted le pagó para proporcionar supervisión con fines de protección a usted. La Parte II le pide información específica acerca de cuándo se proveyó en realidad la supervisión con fines de protección. La Parte III pide información acerca de los pagos que usted hizo cuando recibió supervisión con fines de protección después del período de pagos retroactivos Miller vs. Woods.

PARTE I:

1. NOMBRE DEL SOLICITANTE/BENEFICIARIO (ESCRIBA CON LETRA DE IMPRENTA): | NUMERO DEL SEGURO SOCIAL: | NUMERO DE TELEFONO: ( )

DIRECCION ACTUAL (NUMERO, CALLE): | NUMERO DE ESPACIO/APARTAMENTO:

CIUDAD: | CONDADO: | ESTADO: | ZONA POSTAL:

2. Marque la casilla pertinente por cada una de las siguientes preguntas.
En el período de abril de 1979 a abril de 1984:

	SI	NO
A. ¿Era usted una persona que no tenía control de sí misma, estaba confundida, con impedimentos o enfermedades mentales que hubiera resultado lastimada o lesionada si se le hubiera dejado sola?	☐	☐
B. ¿Le pagó usted a alguien para que cuidara de usted para asegurarse que usted no se lastimara o lesionara?	☐	☐
C. ¿Tenía usted 65 años de edad, o más, estaba ciego(a) o incapacitado(a)?	☐	☐
D. ¿Vivía usted en California?	☐	☐
E. ¿Era la persona a la que le pagó para que cuidara de usted pariente, cónyuge o amistad?	☐	☐
F. ¿Solicitó usted Servicios de Casa y Cuidado Personal (IHSS)?	☐	☐
¿Le negaron los IHSS?	☐	☐

3. Su dirección en la fecha en que usted pagó y recibió supervisión con fines de protección (si es diferente de la anterior).

NUMERO, CALLE: | NUMERO DE ESPACIO/APARTAMENTO:

CIUDAD: | CONDADO: | ESTADO: | ZONA POSTAL:

4. NOMBRE DE LA PERSONA QUE LE PROVEYO SUPERV. CON FINES DE PROTEC. (LETRA DE IMPRENTA): | SU NO. DEL SEGURO SOCIAL: | NUMERO DE TELEFONO: ( )

DIRECCION ACTUAL O ULTIMA DIRECCION CONOCIDA (NUMERO, CALLE): | NUMERO DE ESPACIO/APARTAMENTO:

CIUDAD: | CONDADO: | ESTADO: | ZONA POSTAL:

PARENTESCO QUE TIENE ESTA PERSONA CON USTED:

5. **DECLARACION DEL SOLICITANTE/BENEFICIARIO: Entiendo que la información que he proporcionado arriba y en las partes II y III en el reverso de esta forma, puede ser verificada por dependencias gubernamentales, y entiendo que mi firma en esta forma es una autorización para que se haga dicha investigación. Yo, el suscrito, declaro bajo pena de perjurio que las declaraciones anteriores son verdaderas y correctas.**

FIRMA DEL SOLICITANTE/BENEFICIARIO: | FECHA:

6. **DECLARACION DEL TESTIGO: Yo, el suscrito, declaro bajo pena de perjurio que la persona mencionada en la Sección I de arriba vivió con, pagó, y recibió la supervisión con fines de protección de la persona mencionada en la Sección 4 de arriba.**

NOMBRE DEL TESTIGO (LETRA DE IMPRENTA): | FIRMA DEL TESTIGO: | FECHA:

DIRECCION DEL TESTIGO (NUMERO, CALLE): | NUMERO DE ESPACIO/APARTAMENTO: | NO. DE TELEFONO: ( )

CIUDAD: | CONDADO: | ESTADO: | ZONA POSTAL:

PARENTESCO CON EL SOLICITANTE/BENEFICIARIO: | PARENTESCO CON LA PERSONA QUE PROVEYO SUPERVISION CON FINES DE PROTECCION:

7. NOMBRE DE LA PERSONA QUE COMPLETO ESTA FORMA PARA EL SOLICITANTE/BENEFICIARIO (ESCRIBA CON LETRA DE IMPRENTA):

DIRECCION (NUMERO, CALLE): | NUMERO DE ESPACIO/APARTAMENTO: | TELEFONO: ( )

CIUDAD: | CONDADO: | ESTADO: | ZONA POSTAL:

FIRMA: | PARENTESCO CON EL SOLICITANTE/BENEFICIARIO:

8. **Lea cuidadosamente las instrucciones contenidas en el reverso de esta forma. Una vez que haya contestado <u>todas</u> las preguntas en ambos lados de esta forma, regréselo al departamento de bienestar del condado.**

MILLER V. WOODS
APPLICANT/RECIPIENT SUPPLEMENTAL CLAIM FORM

INSTRUCTIONS: Please print. Fill in all information requested. If you need help, contact the IHSS Section of your county welfare department and ask for assistance.

DEADLINE: **You must complete this supplemental claim form and return it to the county welfare department within 45 days of the date on the Notice of Action.**

PART I

1. NAME OF APPLICANT/RECIPIENT (PRINT):

CURRENT OR LAST KNOWN ADDRESS (NUMBER, STREET):			APARTMENT/SPACE NUMBER:
CITY:	COUNTY:	STATE:	ZIP CODE:

PART II

We have no record of you ever having applied for and been denied IHSS during the period April 1979 through April 1984. Please complete the following:

1. Do you have any **information** relating to your IHSS application and denial during the above period? ☐ YES ☐ NO

   If no, proceed to 2.
   If yes, please provide that information in the blanks below:

   A. Who actually applied for IHSS?

   B. Was the application verbal or in writing?

   C. When was the application made?

   D. What services were requested?

2. Do you have copies of any **documentation** relating to your IHSS application and denial during the above period? ☐ YES ☐ NO
   If yes, please attach a copy of all such documentation.

PART III

Please provide the information below:

1. Did you receive Supplemental Security Income/State Supplemental Program (SSI/SSP) benefits (Gold Check) in any of the following years? Place an X below for each year in which SSI/SSP was received.

   ☐ 1979 ☐ 1980 ☐ 1981 ☐ 1982 ☐ 1983 ☐ 1984

2. List your average gross monthly income from all sources for the following years: (include income from live-in spouse and/or child, if applicable.)

   1979_____ 1980_____ 1981_____

   1982_____ 1983_____ 1984_____

3. Did you have average monthly liquid resources (cash, checking or savings account, trust funds, checks or cash in safety deposit box, stocks or bonds, notes, mortgages, deeds) that were in excess of $1500 (if you were single) or $2250 (if you were married) during the years April 1979 - April 1984? ☐ Yes ☐ No

   If Yes, place an X below for the year(s) in which the your average monthly liquid resources were more than $1500 (if single) or $2250 (if married).

   ☐ 1979 ☐ 1980 ☐ 1981 ☐ 1982 ☐ 1983 ☐ 1984

PART IV

1. **APPLICANT/RECIPIENT STATEMENT:**
   BE SURE YOU HAVE READ AND ANSWERED ALL THE QUESTIONS ABOVE.
   READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING.

   - **I understand that the information I put on this form may be verified and that my signature on this form is an authorization for such an investigation.**
   - **I, the undersigned, declare under penalty of perjury that the answers I have given are correct and true.**

SIGNATURE OF APPLICANT/RECIPIENT:	DATE:

2. **WITNESS' STATEMENT:**

   I, THE UNDERSIGNED, DECLARE UNDER PENALTY OF PERJURY THAT THE ANSWERS PROVIDED ABOVE BY THE APPLICANT/RECIPIENT ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

NAME OF WITNESS (PRINT):	SIGNATURE OF WITNESS:	DATE:

ADDRESS:	CITY:	COUNTY:	STATE:	ZIP CODE:

RELATIONSHIP TO APPLICANT/RECIPIENT:

RELATIONSHIP TO PERSON WHO PROVIDED PROTECTIVE SUPERVISION:

3. NAME OF PERSON COMPLETING THIS FORM FOR THE APPLICANT/RECIPIENT (PRINT):

ADDRESS (STREET, NUMBER):	APARTMENT/SPACE NUMBER:	TELEPHONE NUMBER: ( )

CITY	COUNTY:	STATE:	ZIP CODE:

SIGNATURE:	RELATIONSHIP TO APPLICANT/RECIPIENT:

MILLER vs. WOODS
FORMA SUPLEMENTAL DE RECLAMO PARA EL SOLICITANTE/PERSONA QUE RECIBE BENEFICIOS

INSTRUCCIONES: Por favor escriba con letra de imprenta. Anote toda la información que se le pide. Si necesita asistencia, comuníquese con la Sección de IHSS del departamento de bienestar de su condado y pida que le ayuden.

PLAZO: **Usted tiene que completar esta forma suplemental de reclamo y regresarla al departamento de bienestar del condado en un plazo de 45 días contados a partir de la fecha que aparece en la Notificación de Acción.**

PARTE I

1. NOMBRE DEL SOLICITANTE/PERSONA QUE RECIBE BENEFICIOS (ESCRIBA CON LETRA DE IMPRENTA):

DIRECCION ACTUAL O ULTIMA DIRECCION DE QUE SE SABE (NUMERO, CALLE): | NUMERO DE ESPACIO/APARTAMENTO:

CIUDAD: | CONDADO: | ESTADO: | ZONA POSTAL:

PARTE II

No tenemos información indicando que usted alguna vez haya solicitado servicios de IHSS y que se los hayan negado durante el período de abril de 1979 a abril de 1984. Por favor complete lo siguiente:

1. ¿Tiene usted cualquier **información** relativa a su solicitud para IHSS y su negación durante el perido indicado arriba? ☐ SI ☐ NO

   Si no, pase al 2.
   Si sí, por favor anote la información en los espacios en blanco que se proporcionan enseguida:

   A. ¿Quién fue la persona en particular que solicitó IHSS?

   B. ¿Se presentó la solicitud verbalmente o por escrito?

   C. ¿Cuándo se presentó la solicitud?

   D. ¿Qué servicios se solicitaron?

2. ¿Tiene copias de cualesquier **documentos** relacionados a su solicitud para IHSS y su negación durante el período mencionado arriba? ☐ SI ☐ NO
   Si sí, por favor adjunte una copia de dichos documentos.

PARTE III

Por favor proporcione la información que se menciona enseguida:

1. ¿Recibió usted beneficios de Seguridad de Ingreso Suplemental/Programa Suplementario del Estado (SSI/SSP) (cheque dorado) en cualquiera de los años siguientes? Ponga una X enseguida por cada año en que haya recibido SSI/SSP.

   ☐ 1979 ☐ 1980 ☐ 1981 ☐ 1982 ☐ 1983 ☐ 1984

2. Anote sus ingresos brutos mensuales medios procedentes de todas las fuentes con relación a los siguientes años (incluya los ingresos del cónyuge con el que vive y/o hijo(a) si es pertinente):

   1979_____ 1980_____ 1981_____

   1982_____ 1983_____ 1984_____

3. ¿Tuvo recursos convertibles en efectivo mensuales medios (dinero en efectivo, cuenta de cheques o de ahorros, fondos en fideicomiso, cheques o efectivo en una caja de seguridad, acciones o bonos, pagarés, hipotecas escrituras) que excedían $1,500 (si usted era soltero(a)) o $2,250 (si usted era casado(a)) durante los años abril de 1979 a abril de 1984? ☐ Sí ☐ No

   Si sí, coloque una X enseguida con respecto a los años en los cuales sus recursos convertibles en efectivo mensuales medios excedieron $1,500 (si era soltero) o $2,250 (si era casado).

   ☐ 1979 ☐ 1980 ☐ 1981 ☐ 1982 ☐ 1983 ☐ 1984

PARTE IV

1. **DECLARACION DEL SOLICITANTE/PERSONA QUE RECIBE BENEFICIOS.**
   ASEGURESE DE HABER LEIDO Y CONTESTADO TODAS LAS PREGUNTAS ANTERIORES.
   LEA LAS DECLARACIONES SIGUIENTES CUIDADOSAMENTE ANTES DE FIRMAR.

   - **Entiendo que la información que he incluido en esta forma puede ser verificada, y que mi firma en la misma es una autorización para que se haga dicha investigación.**
   - **Yo, el/la suscrito(a), declaro bajo pena de perjurio que las respuestas que he dado son correctas y verdaderas.**

FIRMA DEL SOLICITANTE/PERSONA QUE RECIBE BENEFICIOS: | FECHA:

2. **DECLARACION DEL TESTIGO.**

   YO, EL SUSCRITO(A), DECLARO BAJO PENA DE PERJURIO QUE LAS RESPUESTAS QUE EL SOLICITANTE/PERSONA QUE RECIBE BENEFICIOS DIO ARRIBA, SON CORRECTAS Y VERDADERAS SEGUN MI LEAL SABER Y ENTENDER.

NOMBRE DEL TESTIGO (ESCRIBA CON LETRA DE IMPRENTA): | FIRMA DEL TESTIGO: | FECHA:

DIRECCION: | CIUDAD: | CONDADO: | ESTADO: | ZONA POSTAL:

PARENTESCO/RELACION CON EL SOLICITANTE/PERSONA QUE RECIBE BENEFICIOS:

PARENTESCO/RELACION CON LA PERSONA QUE PROPORCIONO LA SUPERVISION CON FINES DE PROTECCION:

3. NOMBRE DE LA PERSONA QUE COMPLETA ESTA FORMA POR EL SOLICITANTE/PERSONA QUE RECIBE BENEFICIOS (ESCRIBA CON LETRA DE IMPRENTA):

DIRECCION (CALLE, NUMERO): | NUMERO DE APARTAMENTO/ESPACIO: | NUMERO DE TELEFONO: ( )

CIUDAD: | CONDADO: | ESTADO: | ZONA POSTAL:

FIRMA | PARENTESCO/RELACION CON EL SOLICITANTE/PERSONA QUE RECIBE BENEFICIOS:

MILLER V. WOODS

APPLICANT/RECIPIENT UNDERPAYMENT ELIGIBILITY DETERMINATION WORKSHEET - PART I

APPLICANT/RECIPIENT'S NAME:		SOCIAL SECURITY NUMBER:
PROVIDER'S NAME:	SOCIAL SECURITY NUMBER:	CASE NUMBER:

1. Was provider a spouse? ☐ YES ☐ NO

   If yes, deny underpayment claim, refer claimant to WRO and attach a WRO Provider Standard Claim Form.

   If no, proceed to #2.

2. Did the claimant answer yes to questions 2A, B, C and D on the Applicant/Recipient Standard Claim Form? ☐ YES ☐ NO

   If no, deny underpayment claim.

   If yes, proceed to #3.

3. Did the claimant answer yes to the first part of question F on the Applicant/Recipient Standard Claim Form? ☐ YES ☐ NO

   If no, deny underpayment claim. (Enter here and Part II, Column 2)

   If yes, proceed to #4.

   If unknown, send a Applicant/Recipient Supplemental Claim Form.

4. Did the claimant file for Miller I? ☐ YES ☐ NO

   If yes, proceed to #5.

   If no, proceed to #7.

5. Was Miller I claim denied? ☐ YES ☐ NO

   If yes, deny underpayment claim.

   If no, proceed to #6.

6. Was the Miller I claim approved through the end of the retroactive payment period (April 1979 through April 1984)? ☐ YES ☐ NO

   If yes, proceed to #9.

   If no, deny underpayment claim.

7. Is the claimant eligible for retroactive payments? ☐ YES ☐ NO

   If no, deny underpayment claim.

   If yes, proceed to #8.

8. Is claimant eligible for retroactive payments through the end of the retroactive period (April 1979 through April 1984)? ☐ YES ☐ NO

   If no, deny underpayment claim.

   If yes, proceed to #9.

9. Was there an IHSS case record? ☐ YES ☐ NO

   If no, CMIPS will calculate underpayments using NSI maximums, not to exceed the allowable maximum for any given month, including previously authorized services. Proceed to Part II.

   If yes, proceed to #10.

10. Check (✔) one of the following. Recipient was ☐ severely impaired (SI) ☐ non-severely impaired (NSI)

    If SI, CMIPS will calculate underpayments at the SI maximums. (Enter here and Part II, Column 7)

    If NSI, CMIPS will calculate underpayments at the NSI maximums. Proceed to Part II.